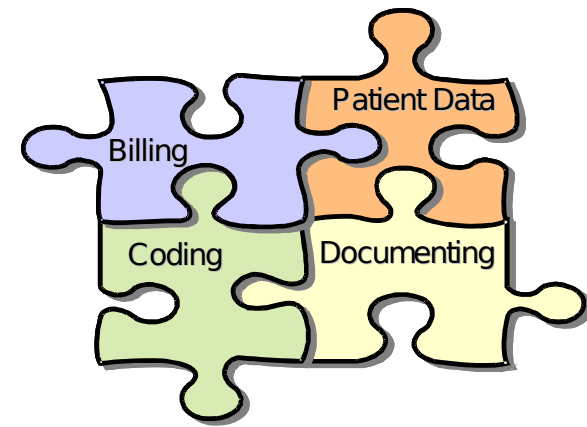


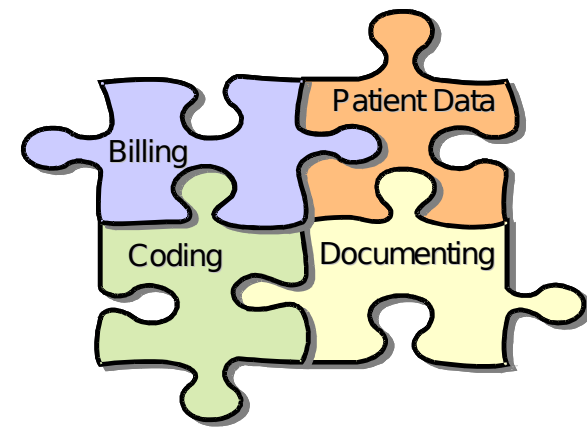
2005 UBU/UBO Conference

Tuesday - May 17



Contents:

- 1. Civilian Vs Military Coding (Yoder and Burns)**
- 2. Healthcare Common Procedure Coding System (HCP CS), The Other Coding Book (Gowen, Michele)**
- 3. Inpatient Professional Services Coding (Pierson, Cindy)**
- 4. Institutional Coding - The Standard Inpatient Data Record (SIDR) (Pierson, Cindy)**
- 5. Coding from the Trenches (Millican, Lesvia)**



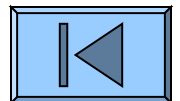
Civilian Vs Military Coding

Lt Col Jeanne Yoder, RHIA, CPC, PMNCC, CCS-P

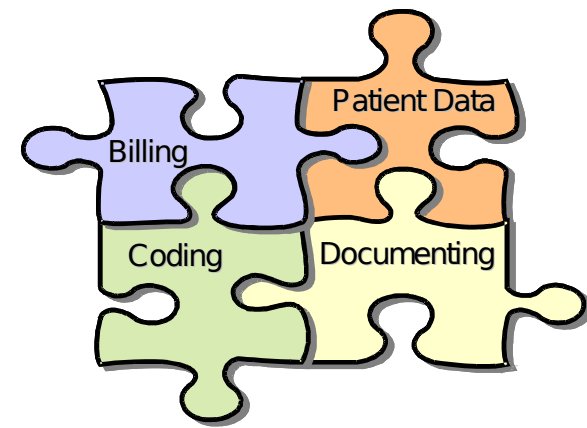
Anne Burns, CPC, PMCC

May 17, 2005

Track 1, UBO

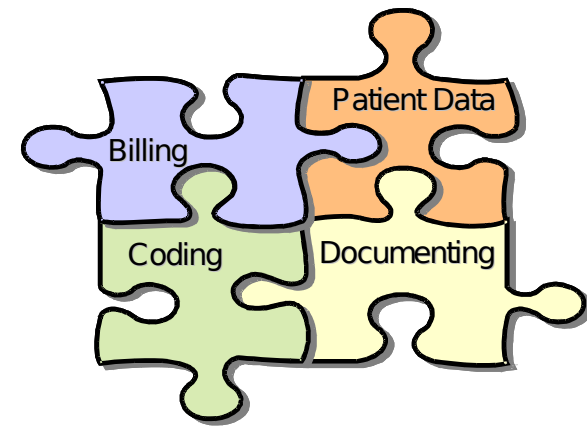


Objectives



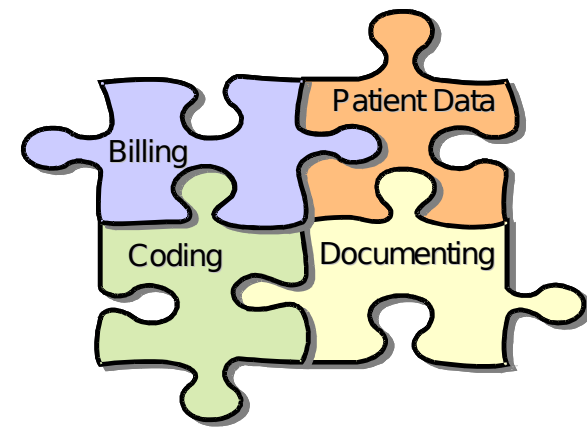
- Introduction to military coding for those
 - Interested in coding opportunities with the military
 - Interested in working with the military on billing activities
 - Interested in using military data for research

Civilian Vs Military Coding



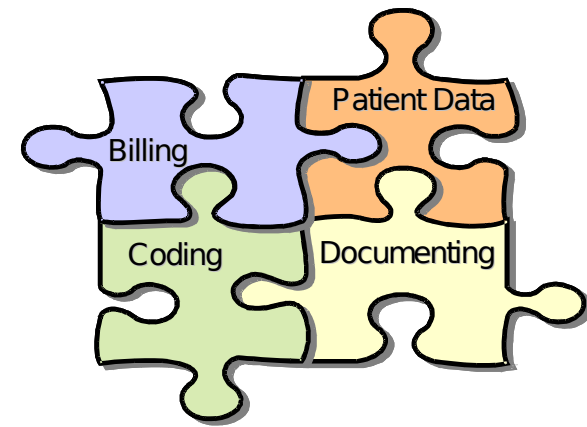
- Introduce the Unified Biostatistical Utility (UBU) concept. The UBU is the coding oversight organization for the military.

BOTTOM LINE



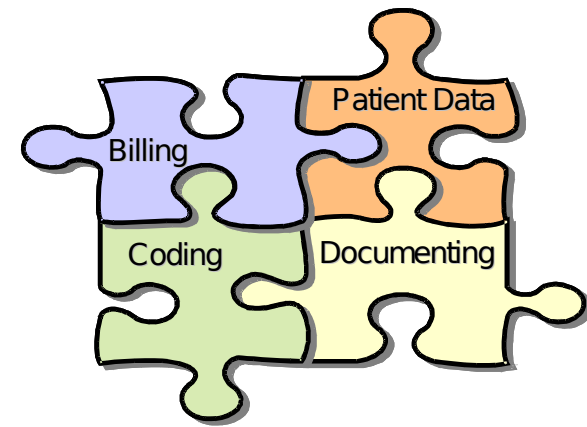
- We hope to dispel the “mystery” of coding for the military.
- We will show you that while coding for a military treatment facility (MTF = hospital) is different, it is still good, basic coding.

Military Coding Background



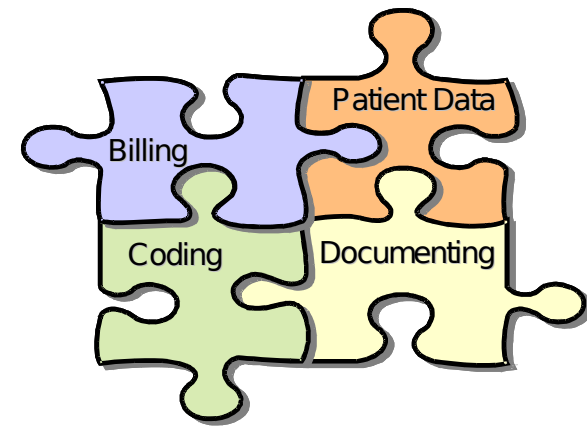
- 150 separately organized Military Medical Treatment Facilities (MTFs)
- Army, mostly supporting posts with large populations, usually hospitals with associated clinics
- Navy, mostly supporting bases with medium size populations with small hospitals, except for large port bases with larger hospitals/medical center (e.g., San Diego). Supports Marines.
- Air Force, mostly supporting bases with small populations (lots of clinics) with a few referral/teaching larger hospitals

Military Coding History



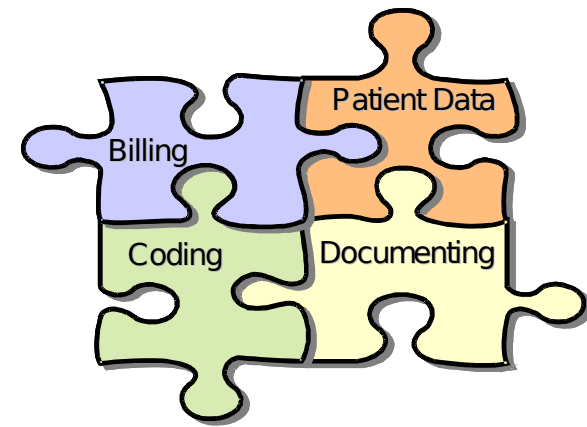
- Where the money comes from now
 - Military Prospective Payment System
 - Relative Weighted Product for inpatient institutional
 - Relative Value Unit for outpatient professional
 - Collect RVUs from both “Privileged Providers” and “nurses, technicians”
 - About \$150 Million collected from Third Party Billing for 9.1 Million beneficiaries, 150 facilities
 - Other funds from other billing (not insurance companies)
 - DVA, CMS, foreign countries, subsistence, Coast Guard

Military Coding History



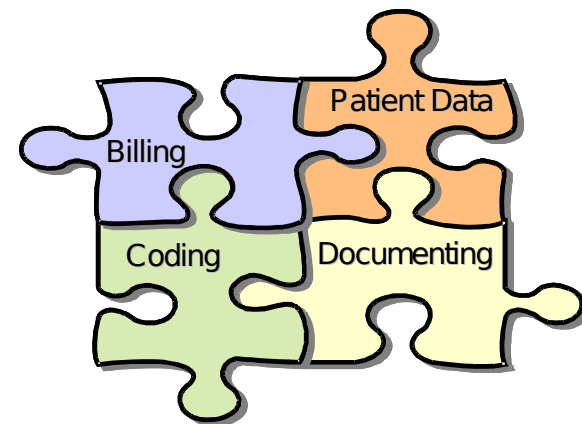
- Other major uses of data
 - HEDIS (Health Plan Employer Data and Information Set) by the National Committee for Quality Assurance
- Military Mission
 - Deployment Related
 - Preventive Health Assessments
 - Overseas Clearances
 - Substance Abuse Rehabilitation Clinic (SARC)

Civilian Coding History



- Originally diagnosis coding for research
- Then for hospital accreditation
- Then with Medicare, finally coded data was associated with billing
- Then in the 1983, CPT came out from the American Medical Association.
- RBRVS

Code Sets



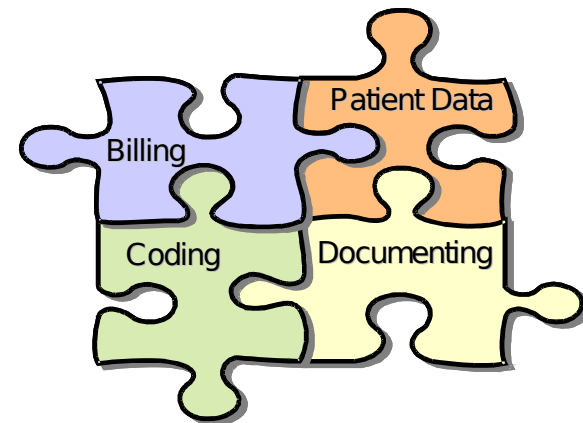
Military Institutional

- Inpatient, ICD-9-CM, volumes 1, 2, 3
- Pass-through items - usually not coded
- Ambulatory Procedure Visits, 99199
- Emergency Department, 9928x reflects both institutional and professional combined
- Observation, don't code institutional component
- Injuries - Standard NATO Agreement Codes and E-codes

Civilian Institutional

Inpatient, ICD-9-CM, volumes 1, 2, 3
Pass-through items - HCPCS
Same-day-surgeries, CPT/HCPCS on UB 92
Emergency Department, use a revenue code on the UB 92
Observation, use revenue code on UB 92
Injuries - only the ICD-9-CM E-codes

Code Sets



Military Professional

- “E&M” codes - 99201-99499 collected in mandatory separate field
Diagnosis/V-codes/E-codes
- ICD-9-CM vols 1 and 2
- CPT and HCPCS other than 99201-99499 collected in separate field

Civilian Professional

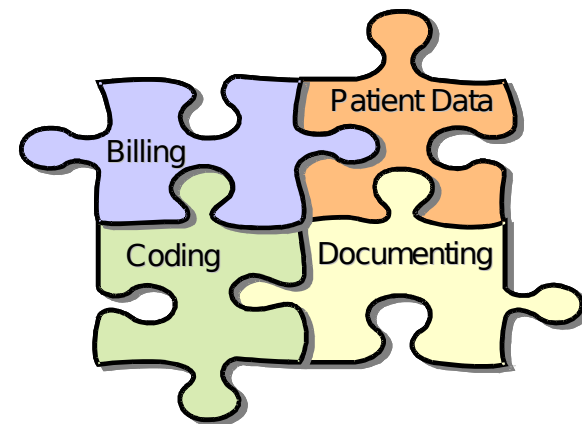
Diagnosis/V-codes/E-codes - ICD-9-CM vols 1 and 2

CPT and HCPCS all collected in same field, no separation of 99201-99499

CPT 99201-99499

Military

- Mandatory, separate field for collecting 99201-99499
- If no applicable code from 99201-99499,
 - use **99499** for privileged providers and technicians/nurses doing a procedure
 - Use 99211 for technicians/nurses not doing a procedure



Civilian

Use if appropriate.

Don't use if not appropriate

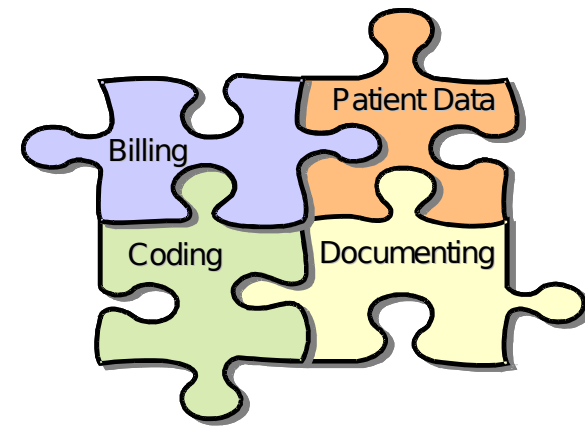
Modifiers

Military

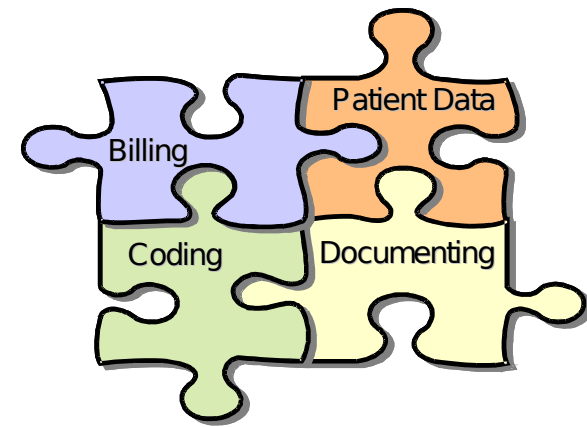
- Not all available;
 - Some are accepted in the system and stay at the MTF
 - Some may be entered, but do not feed to the MTF database
 - Some the system rejects and will not permit to be entered
- See slide after “Questions” for those that are stored on the MTF server

Civilian

All available



ABN - Advance Beneficiary Notification



Military

- Not done

Civilian

Issued before service or procedure is performed if the service or procedure may not be covered by the insurance company

Anesthesia, Outpatient

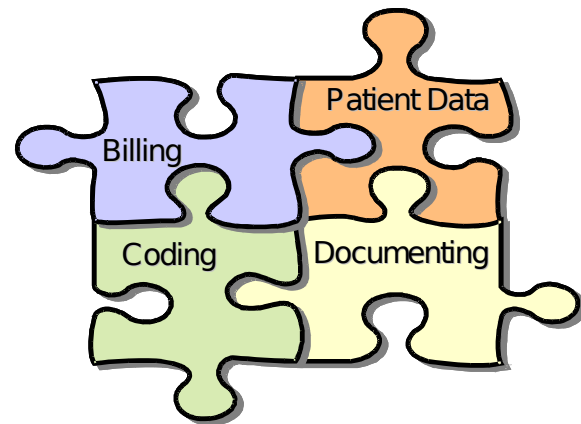
Military

- Only code actual anesthesia provider, not direction or supervision
- System doesn't accept modifiers
- Enter total minutes of service in "units" field (2 hours = 120 minutes)

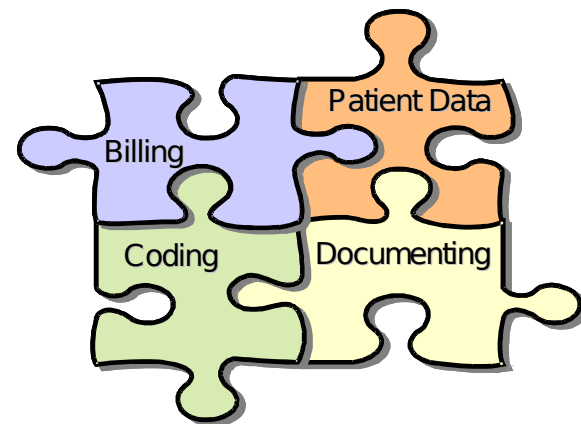
Civilian

Codes separate providers separately, a charge for anesthesiologist doing direction or supervision; one charge for the CRNA doing the actual anesthesia

Use appropriate modifiers



Anesthesia, Inpatient



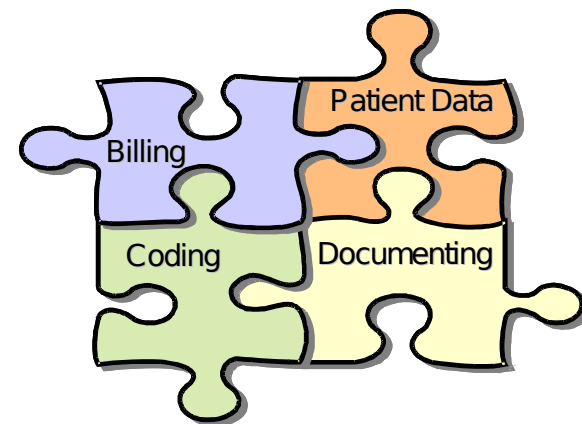
Military

- Don't code anesthesia provider (e.g., anesthesiologist, certified registered nurse anesthetist) professional component at this time as it is difficult to separate from outpatient anesthesia and we don't separately bill inpatient anesthesia

Civilian

Code with modifier 47 when surgeon personally performed the entire anesthesia and surgical services alone:
Code anesthesia provider for Monitored Anesthesia Care an anesthesia
Code medical direction and supervision using the appropriate modifiers

Ambulance



Military

- Use applicable HCPCS code
- Units are collected in minutes of service
- Billed one flat rate no matter the number of minutes or miles

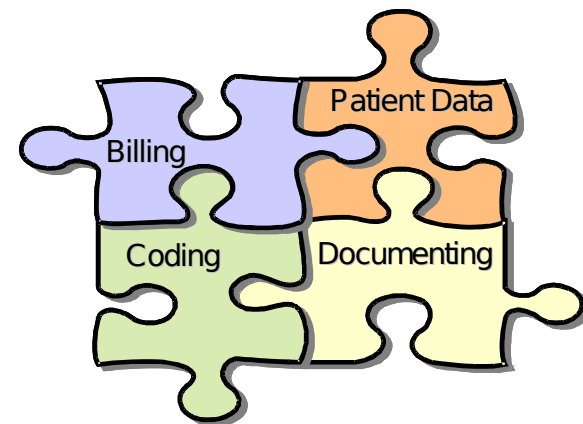
Civilian

Use applicable HCPCS code

Units are collected in miles

For ambulance services and supplies furnished, the Medicare allowed amount is based on 80% of the national fee schedule and 20% of the provider's or supplier's reasonable cost (1/1/5-12/31/05)

Ambulatory Procedure Visit Institutional



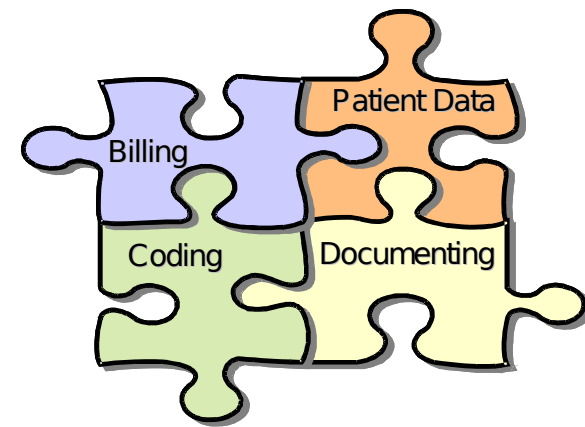
Military

- On the Standard Ambulatory Data Record, use the code “99199” as the last or if more than 4 procedures, the 4th procedure code

Civilian

- Institutional component billed on the UB 92 with the appropriate revenue code, no CPT/HCPCS

Ancillary - Radiology/Lab



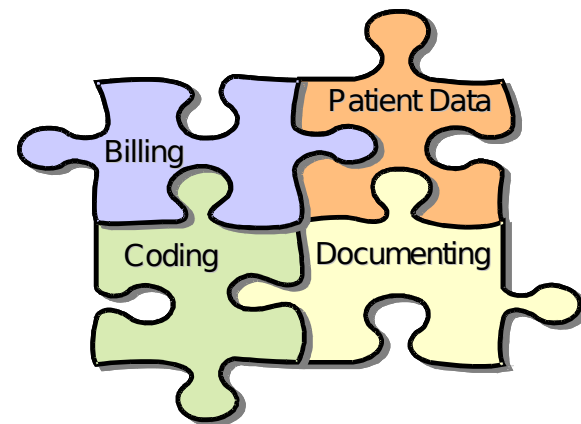
Military

- Military coding committee, UBU, not involved
- Based on provider's order which is linked to a CPT code. When the study is completed, the CPT code flows to the data warehouse

Civilian

Code according to coding guidelines
Usually provider groups
Laboratory has option of billing provider or insurance company
Radiology usually bills insurance company for both professional and technical components

Dental



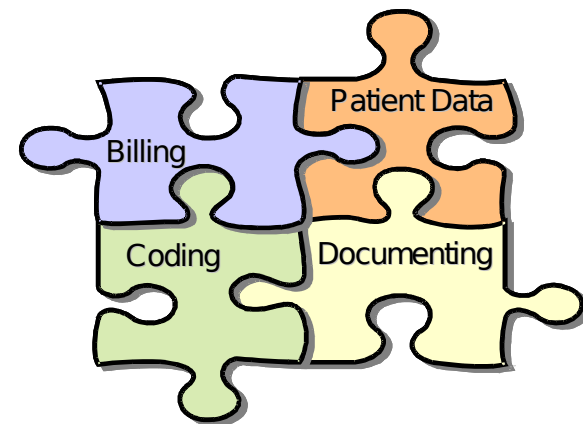
Military

- Military coding committee, UBU, not involved

Civilian

Use HCPCS
“D” codes by
the American
Dental
Association

Deployment Related



Military

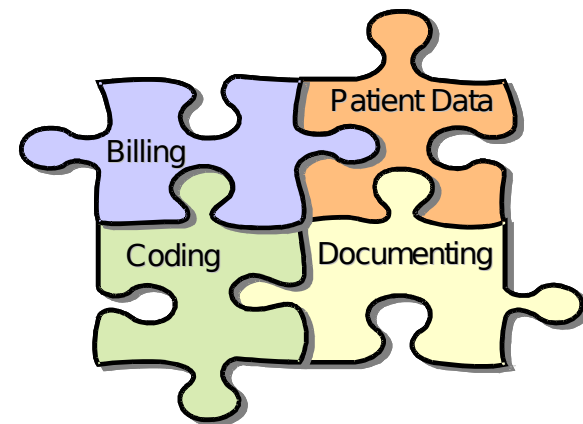
- Any encounter that has a portion for care related to a deployment must have V70.5 6 as the first listed code.

Civilian

HUH???

Does not exist in civilian coding, would sort of be like a E-code

Dialysis



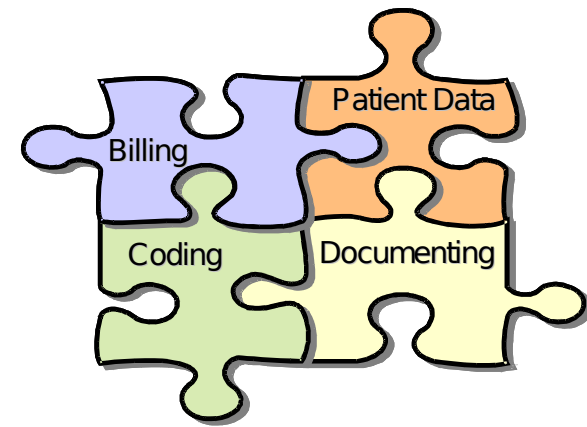
Military

- Military coding committee, UBU, not involved

Civilian

Doctors may code for monthly service (for 30 consecutive days by month) or by individual treatment dates to get you to the 1st of the month; if hospitalized; or leave the area

DoD Extenders



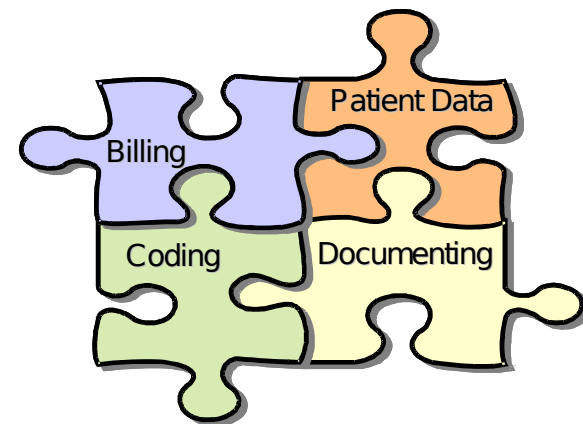
Military

- For certain diagnoses, the military needed more granularity.
- See handout

Civilian

Ha Ha
Nothing like
this either.

Durable Medical Equipment



Military

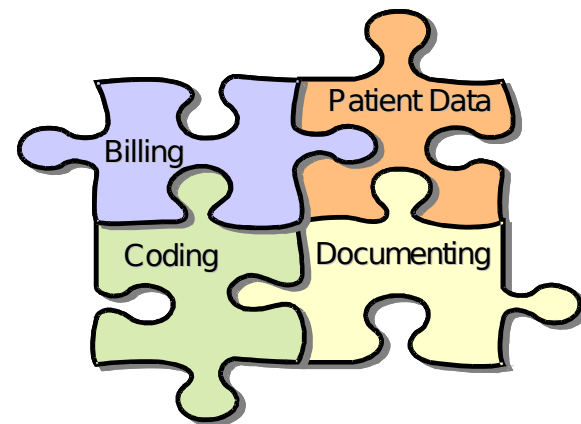
- If normal supply, part of E/M
- If consumable (e.g., CPAP mask), code it
- If loaned to patient, but will be returned (e.g., TENS unit), don't code it

Civilian

If a supply handed out in the office, may be included in the E/M level of service.

If over \$ amount code it with appropriate modifier
Pharmacy provides DME and bills DME carriers directly using HCPCS and modifiers

EKGs



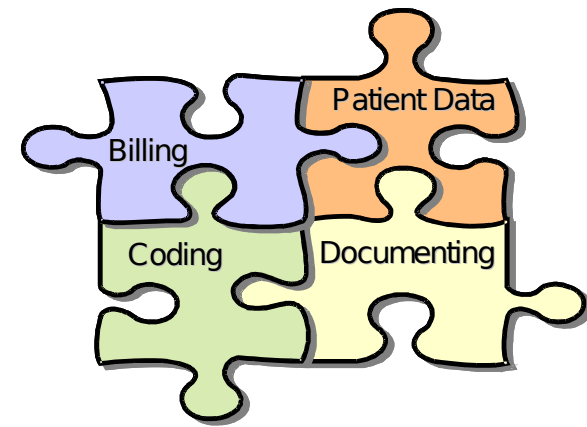
Military

- May code in either clinic, or ancillary, or split professional in clinic and technical in ancillary
- If in ancillary, sometimes billed, sometimes not

Civilian

If done in office,
both professional
and technical
components billed
If done in outpatient
hospital setting,
physician bills only
the I&R

Global Package



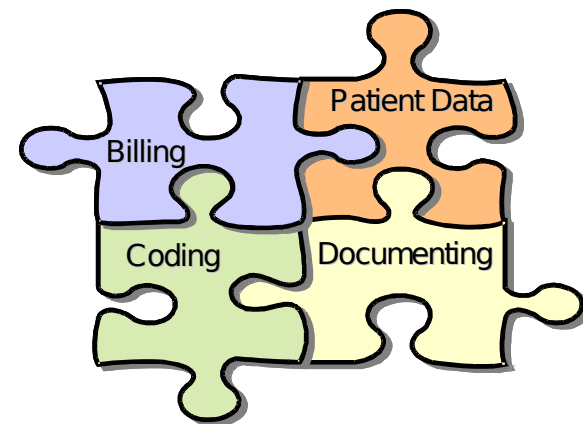
Military

- Trying to use it
- Problems with:
 - Emergency room services not being coded with -54
 - Follow-up care not using modifier -55, then 99024 for additional routine f/u

Civilian

Experienced using global package correctly

Home Health



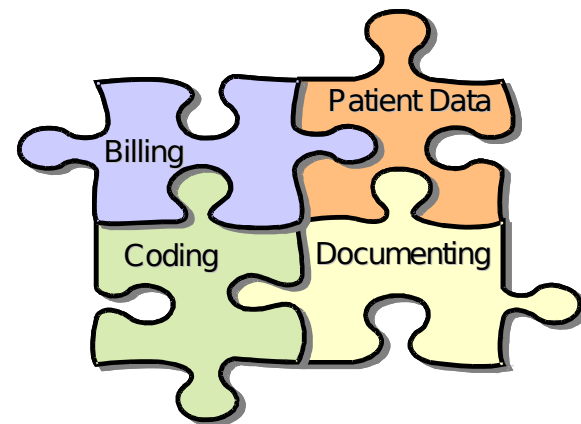
Military

- If done by a nurse outside the “4-walls of the military medical treatment facility” don’t code it

Civilian

Private agencies perform service; visits and services coded and insurance carriers billed directly

Inpatient Professional



Military

- Encouraged to code
- Code non-surgical rounds
- Code surgical procedures
- Code complications of surgery
- Don't code routine post operative care which is part of global
- Billed as 4% of institutional bill

Civilian

Code inpatients other than those that are part of the global

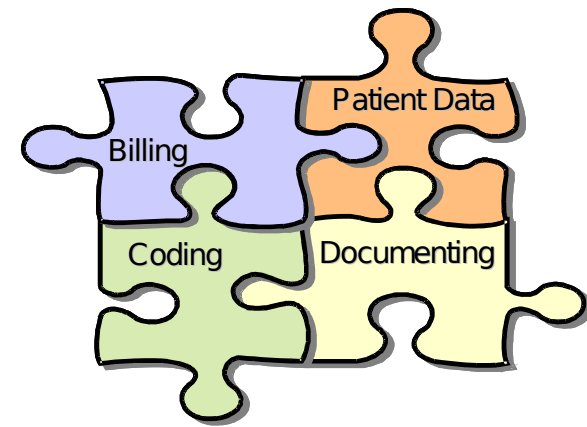
Code surgical procedures

Code complications of surgery

Code routine post operative care visits

Document and track, but don't code routine post operative care which is part of global

J-Codes (Injectables)



Military

- If issued to the patient through the pharmacy, do not code as the pharmacy will collect data
- If part of routine office visit do not code
- If special ordered for the patient through Medical Logistics, use J/C/S- pharmaceutical if available

Civilian

When used in the office, J-codes (and C/S-codes) are coded and billed

When used in the hospital setting, physician does not code, it is part of the facility cost

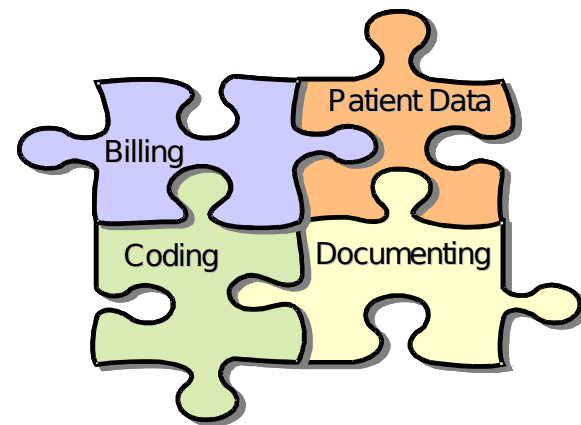
Obstetrics

Military

- Tracks all encounters
- Same group practice does ante partum, delivery and postpartum
- AP and PP billed on CMS 1500
- Delivery billed as part of "Inpatient" bill
- Can't use global concept as work in two different cost centers

Civilian

- Tracks all encounters
- Same group practice does ante partum, delivery and post partum
- Professional services coded and billed on CMS 1500
- If patient has to change physician group part way through pregnancy, can code and bill accordingly



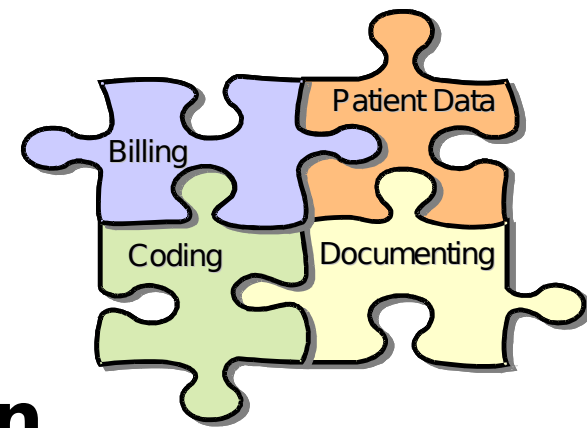
Supplies

- **Military**

- Issue glasses and hearing aids, don't code yet
- No clear guidance on what to code
- HCPCS "L" prosthetic coding doing well
- No billing DME due to coding quality concerns

Unified Biostatistical Utility/Uniform

Business Office Conference 2005



- **Civilian**

- Coverage determined by individual's insurance policy

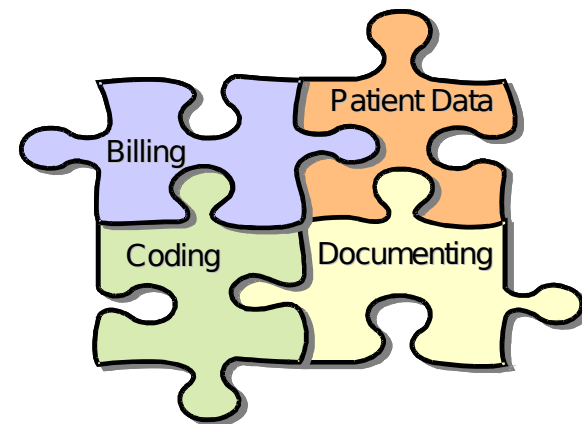
Motivation

Military

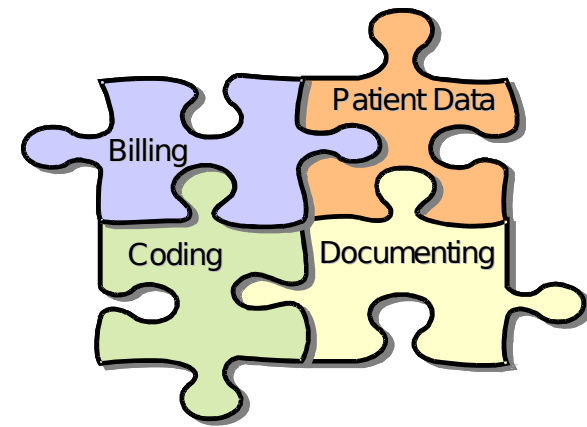
- Limited rewards to provider for proper documentation or to clinical service for correct billing
- Physicians nearing separation or retirement are more motivated to learn/apply correct coding
- Over coding (highly unusual) usually due to not understanding coding

Civilian

- Financial motivation to know documentation rules and to code correctly

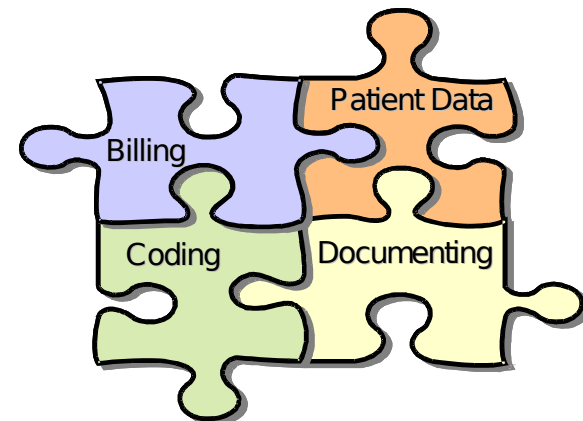


Questions



- See the UBU Coding Guidelines at:
- <http://www.tricare.osd.mil/org/pae/ubu/default.htm>

Modifiers in Military System



Modifiers Available in the DoD for E&M in the range 99201-99499.

- 21 Prolonged E&M services (use only on highest level of E&M)
- 24 Unrelated E&M by same physician during a postoperative period
- 25 Significant, separately identifiable E&M by same physician on same day
- 57 Decision for Surgery

The following modifiers are available and should be used when appropriate for CPT/HCPCS other than E&M in the range of 99201-99499.

22 Unusual procedure services

26 Professional component

32 Mandated services

50 Bilateral procedure

51 Multiple procedures

52 Reduced services

53 Discontinued procedure

55 Post-operative care only

56 Pre-operative care only

58 Staged/related procedure/svs by same physician post-op

59 Distinct procedural service

76 Repeat procedure by same physician

77 Repeat procedure by another physician

78 Return to Operating Room for related procedure during post-op period

79 Unrelated procedure/service by same physician during post-op period

90 Reference (outside) lab

99 Multiple modifiers (do not use in the DoD system)

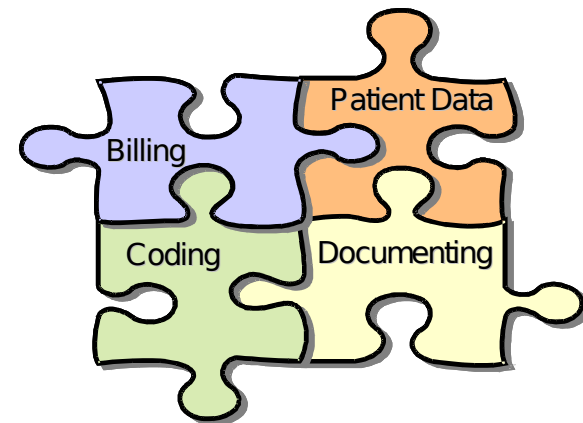
Continued in next column

- The following modifiers are available and should be used when appropriate for CPT/HCPCS other than E&M in the range of 99201-99499.

- CC Procedure code changed, incorrect code filed

- E1 Upper left eyelid
- E2 Lower left eyelid
- E3 Upper right eyelid
- E4 Lower right eyelid
- F1 Left hand, second digit
- F2 Left hand, third digit
- F3 Left hand, fourth digit
- F4 Left hand, fifth digit
- F5 Right hand, thumb
- F6 Right hand, second digit
- F7 Right hand, third digit
- F8 Right hand, fourth digit
- F9 Right hand, fifth digit
- FA Left hand, thumb
- LC Left circumflex coronary artery
- LD Left anterior descending coronary artery
- LT Left
- RC Right coronary artery
- RT Right
- T1 Left foot, second digit
- T2 Left foot, third digit
- T3 Left foot, fourth digit
- T4 Left foot, fifth digit
- T5 Right foot, great toe
- T6 Right foot second digit
- T7 Right foot, third digit
- T8 Right foot, fourth digit
- T9 Right foot, fifth digit
- TA Left foot, great toe
- TC Technical component.

Anesthesia, Outpatient



Military

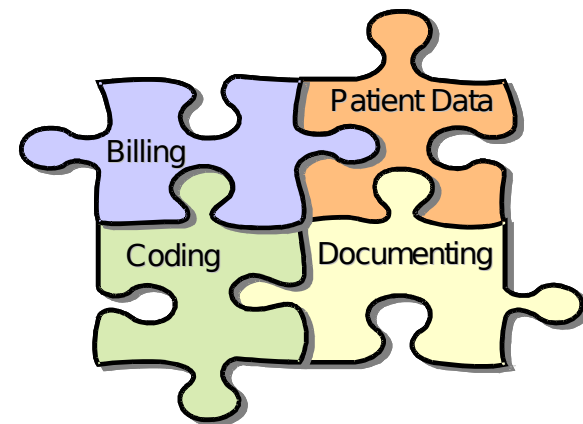
- Only code actual anesthesia provider, not direction or supervision
- System doesn't accept modifiers
- Enter total minutes of service in "units" field (2 hours = 120 minutes)

Civilian

Codes separate providers separately, a one bill for anesthesiologist doing direction or supervision; one for the CRNA doing the actual anesthesia

Use appropriate modifiers

Units usually are "15 minutes of anesthesia time"

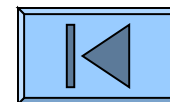


Healthcare Common Procedure Coding System (HCPCS), The Other Coding Book

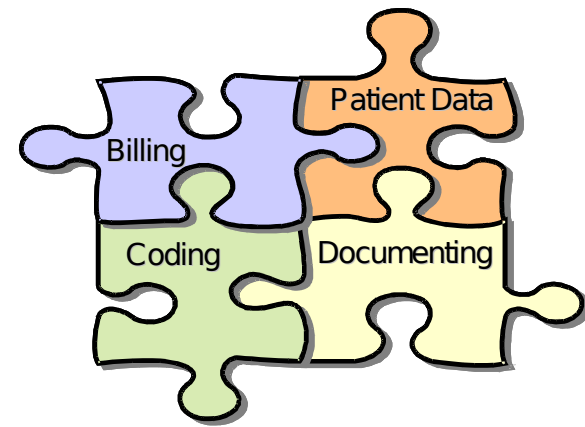
Michele Gowen, RHIA

May 17, 2005

Track 1, UBU

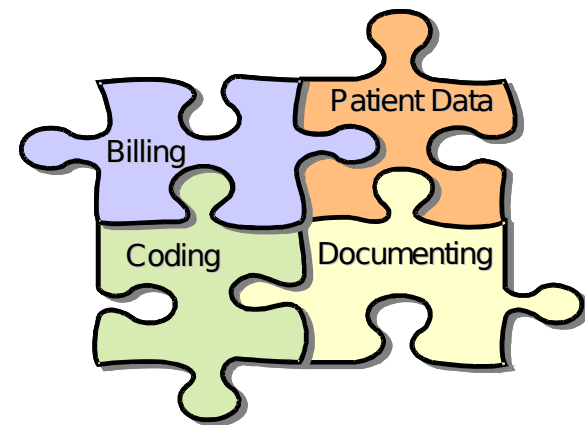


Objectives



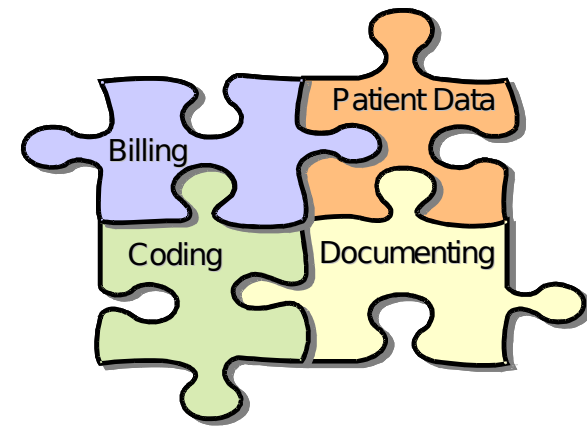
- Define what HCPCS codes are.
- Describe when HCPCS codes are used.
- Describe how HCPCS codes are used.

The What of HCPCS



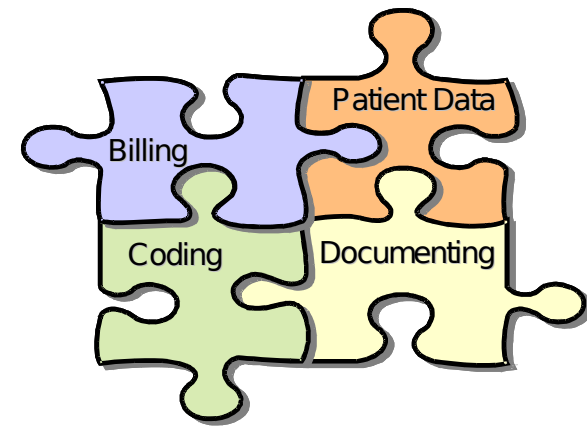
- Types of Procedure Codes
- Background history
- Components of codes
- Levels I, II and III

Types of Procedure Codes



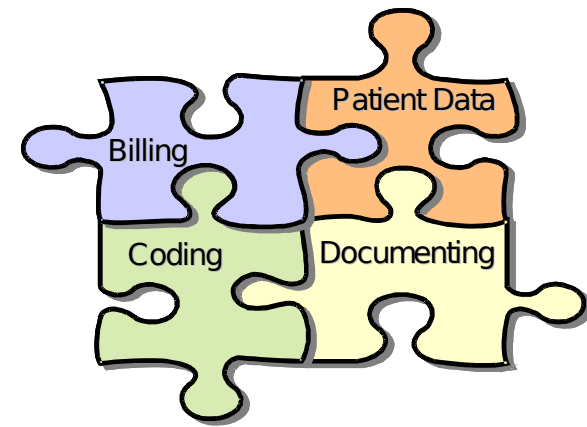
- ICD-9-CM, volume 3 to be used for hospital inpatient coding
- CPT-4 and HCPCS to be used by physicians and other health care services, including hospital outpatient services

Background History of HCPCS



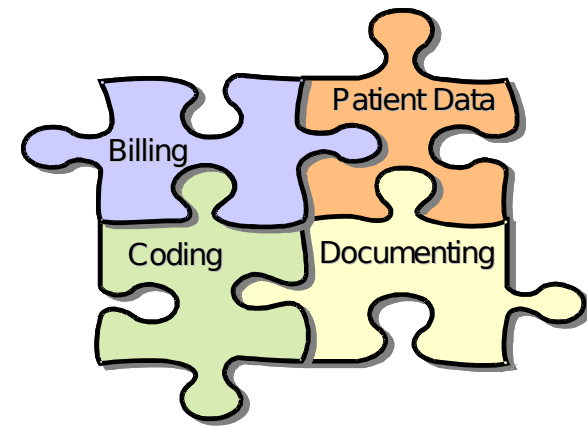
- Omnibus Budget Reconciliation Act of 1986 (OBRA) required CPT/HCPCS coding for outpatient services for federally funded patients
- CMS (formerly called HCFA) developed a three-part system to standardize the coding system used to process Medicare claims
- Developed HCPCS to support the need to bill for all services (not just those in CPT)
- Used for all services: surgical, medical, supplies, materials and injections

Components of HCPCS



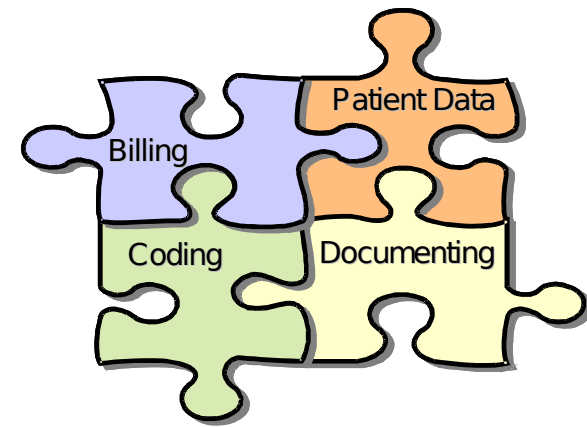
- Level I: CPT Codes
 - 80% of HCPCS can be coded using CPT
- Level II: HCPCS Codes (AKA National Codes)
 - Developed by CMS to identify other services
- Level III: Local Codes
 - Codes developed by local Medicare carriers
 - Discontinued in 2003

Level 1: Current Procedure Terminology (CPT)



- Published, copyrighted by AMA since 1966
- Developed as a method of communication between MDs and third-party payers
- **Intended to be used for reimbursement** (*unlike* ICD-9-CM)
- 5 digit numeric codes
- Updated annually on January 1
- **Official Reference:** *CPT Assistant*

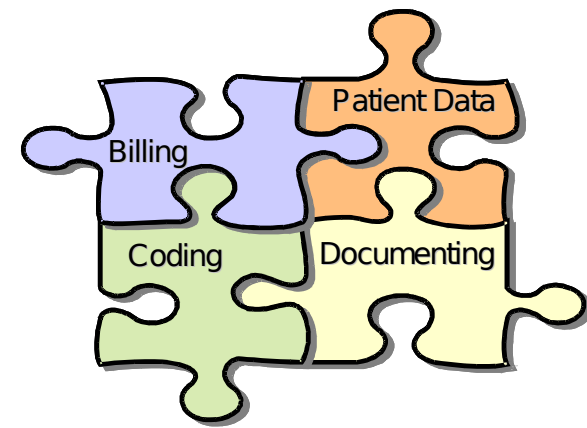
Level II: HCPCS Codes



- One alphabetic character followed by four digits (A0000 – V9999)
- CMS (formerly HCFA) developed the Healthcare Procedural Coding System in 1983.
- Because CPT lacks many codes for nonphysician procedures and services, CMS created codes to supplement CPT and to describe supplies and drugs.
- Required by Medicare but...
 - Used by most insurance companies that understand the value of accurate codes

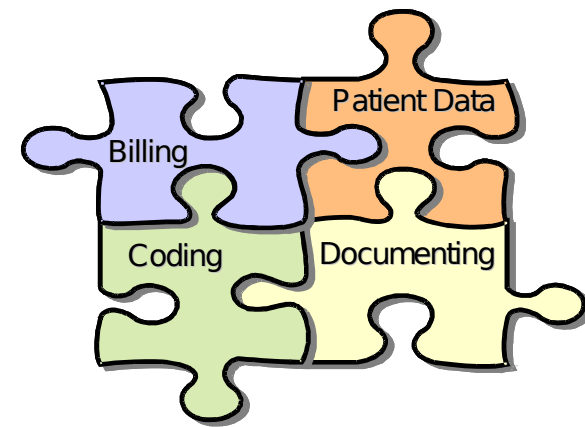
CORE COMPETENCIES

Level II: HCPCS Codes



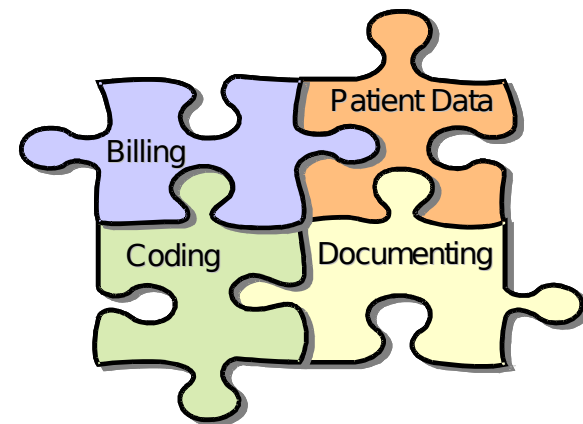
- Allows for continuity and specificity when billing.
- Uniformity helps the effort to collect uniform health service data.
- Codes are approved and maintained jointly by the Alpha-Numeric Workgroup, consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association.
- Codes and descriptions are updated every January by CMS.

Level III: Local Codes



- The Health Insurance Portability and Accountability Act (HIPAA) required there be standardized procedure coding.
- All unapproved HCPCS Level III codes/modifiers were **eliminated in December 2003** to meet this requirement.
- Level II codes have increased 47% because of the loss of local reporting.

When are HCPCS Codes Used?

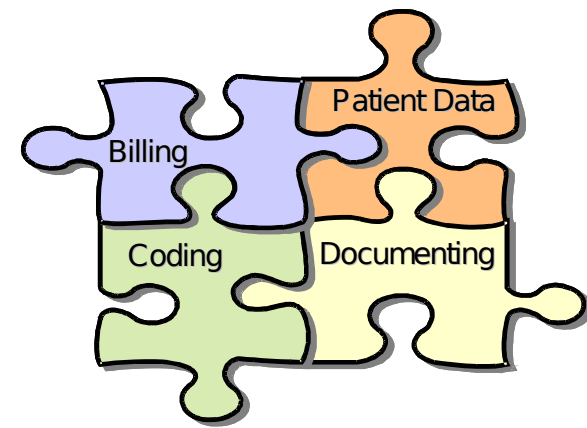


Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines, Procedural Coding 1.3 states:

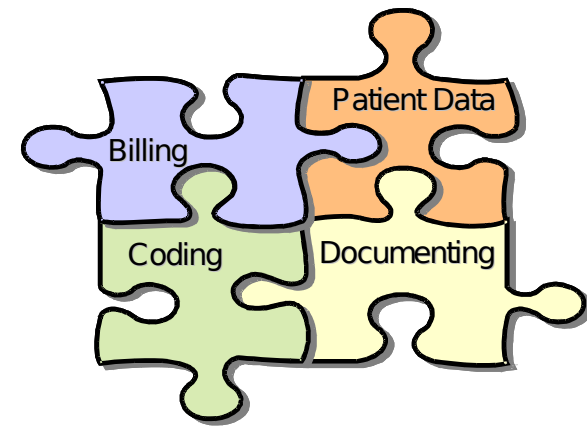
- **Level I** HCPCS are commonly referred to as Current Procedural Terminology (CPT). They form the major portion of the HCPCS coding system, covering most services and procedures. CPT codes supersede Level II codes when the verbiage is identical.
- **Level II** codes supersede Level I codes for similar encounters, when the verbiage of the Level II code is more specific. HCPCS include evaluation and management services, other procedures, supplies, materials, injectables and dental codes. Having a code number listed in a specific section of HCPCS does not usually restrict its use to specific profession or specialty.

HCPCS Organization

- Sections
 - A: ambulance
 - D: dental
 - J: drugs
- Index
- Table of drugs
- Instructions
- Appendices

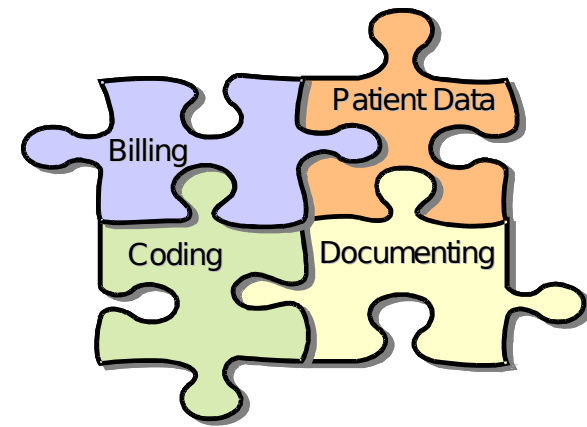


HCPCS Sections



- A0000-A0999 Transportation Services Including Ambulance
- A4000-A8999 Medical and Surgical Supplies
- A9000-A9999 Administrative, Miscellaneous and Investigational
- B4000-B9999 Enteral and Parenteral Therapy
- C codes – Transitional pass-through payment items for the Outpatient Prospective Payment System. These tend to be for high-cost items and should only be coded if it is paid for out-of-clinic funds. Do not code it if the pharmacy issued it to the patient.

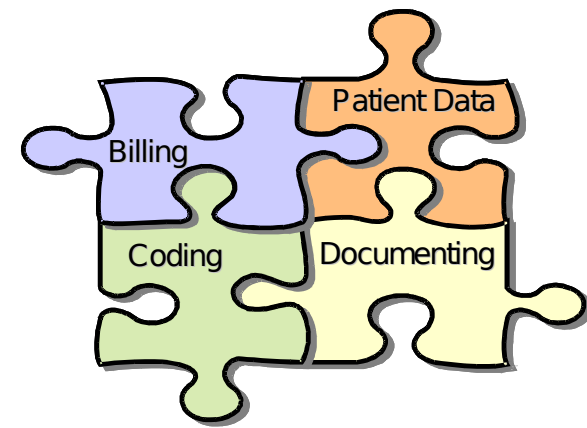
HCPCS Sections



- D codes – American Dental Association codes. They are used by dentists and may be used by oral surgeons in some cases.
- E codes – Durable Medical Equipment (DME)
- G codes – Temporary Procedures/Professional services that CMS assigns for procedures and services that are being considered for inclusion in CPT.
- H codes – Alcohol and Drug Abuse Treatment
- J codes – Drugs Administered Other Than Oral Method

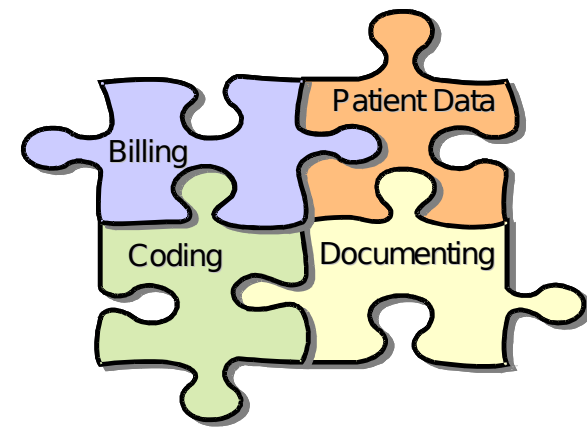
Unified Biostatistical Utility/Uniform
Business Office Conference 2005

HCPCS Sections



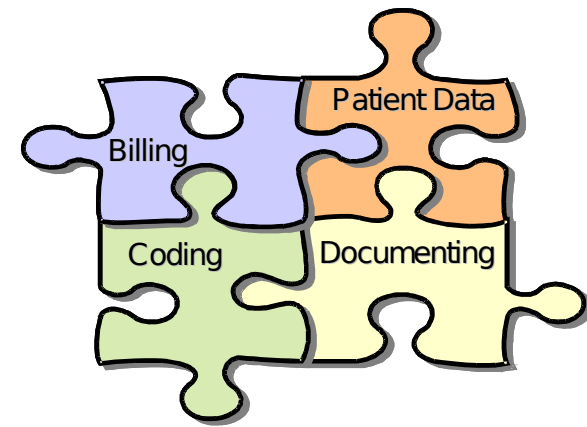
- K codes – Temporary Durable Medical Equipment
- L codes –
 - Orthotic procedures L0000-L4999
 - Prosthetic procedures L5000-L9999
- M codes – Medical services that fall under the jurisdiction of the local carrier (e.g., cellular therapy, prolotherapy, IV chelation, fabric wrapping of abdominal aneurysm)

HCPCS Sections



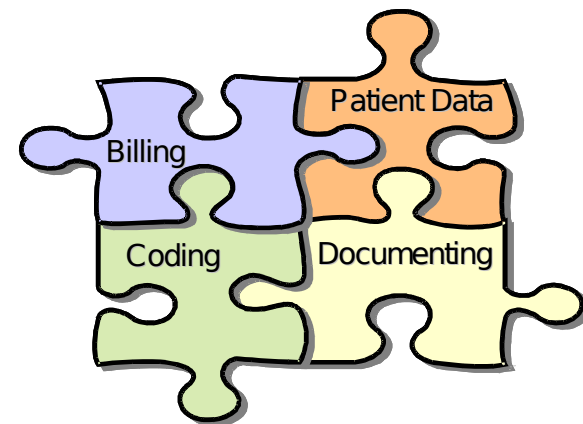
- P codes – Pathology and Laboratory (e.g., chemistry, toxicology and microbiology tests, and various blood products.)
- Q codes – Temporary procedures, services and supplies (Q0091 for screening paps, Q3014 telehealth originating site facility fee, chemotherapy, cast supplies)
- R codes – Radiology

HCPCS Sections



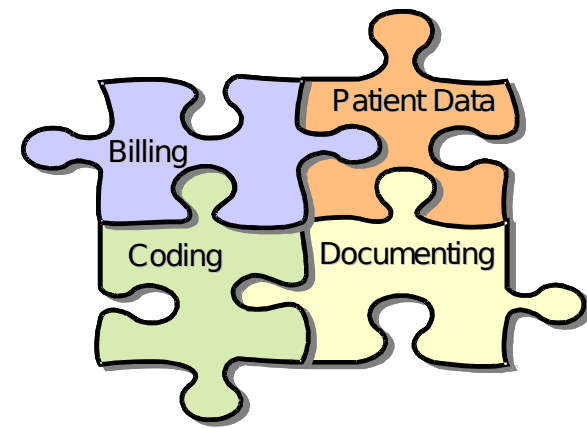
- S codes – Temporary (e.g., S9453 Smoking Cessation)
- T codes – For state Medicaid agencies
- V codes
 - Vision V0000-V2999
 - Hearing V5000-V5999
 - Speech-Language Pathology V5300-V5399

HCPCS Temporary Codes



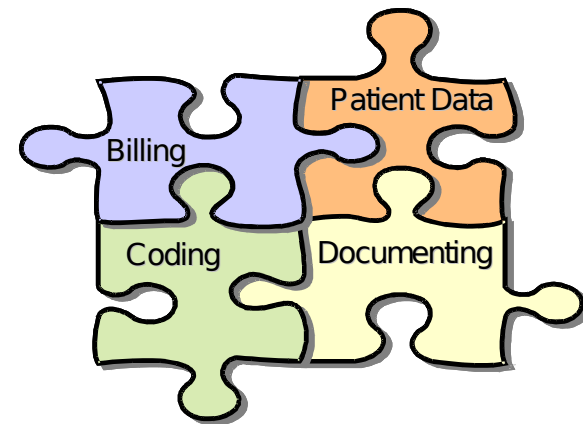
- Sections of HCPCS have codes are being used on a “trial” or “temporary” basis
- To determine if payment can be correctly applied
- To gather statistics about use before a CPT code and a payment amount can be assigned
- These codes are updated throughout the year

HCPCS Temporary Codes: G, K, Q and S



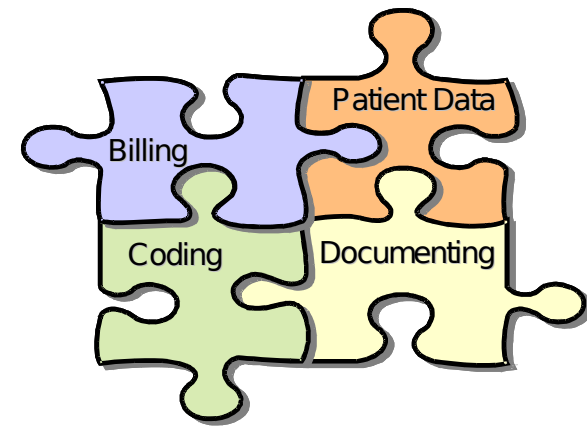
- G codes are used for procedures and professional services.
- K codes are for durable medical equipment (DME).
- Q codes are for procedures, services and supplies.
- S codes are Blue Cross/Blue Shield codes that are not valid for Medicare or Medicaid patients.

Crosswalk for Commonly Used “G” Codes Deleted April 1,2005



- **Instead of code(s): Use this code:**
- **G0230 78459** (heart muscle imaging [PET])
- **G0030, G0032, G0034, G0036, G0038, G0040, G0042, G0044, G0046 78491** (heart image [PET], single)
- **G0031, G0033, G0035, G0037, G0039, G0041, G0043, G0045, G0047 78492** (heart image [PET], multiple)
- **G0229, G0336 78608** (brain imaging [PET])
- **G0125, G0210, G0211, G0212, G0213, G0214, G0215, G0216, G0217, G0218, G0220, G0221, G0222, G0223, G0224, G0225, G0226, G0227, G0228, G0253, G0254, G0296 78811** (tumor imaging [PET], limited)
- **G0125, G0210, G0211, G0212, G0213, G0214, G0215, G0216, G0217, G0218, G0220, G0221, G0222, G0223, G0224, G0225, G0226, G0227, G0228, G0253, G0254, G0296 78812** (tumor image [PET]/skull-thigh)
- **G0125, G0210, G0211, G0212, G0213, G0214, G0215, G0216, G0217, G0218, G0220, G0221, G0222, G0223, G0224, G0225, G0226, G0227, G0228, G0253, G0254, G0296 78813** (tumor image [PET] full body)

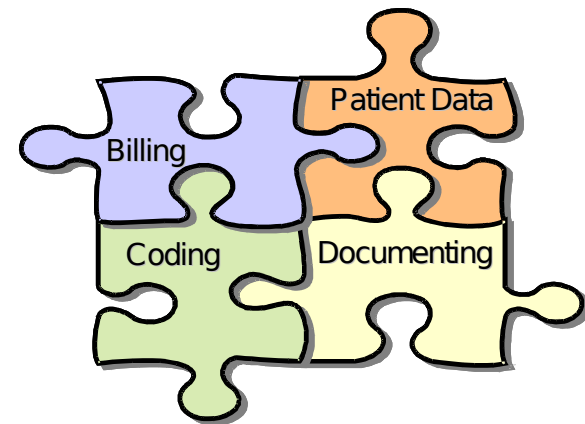
How are HCPCS Codes Used?



HCPCS Codes are used to describe:

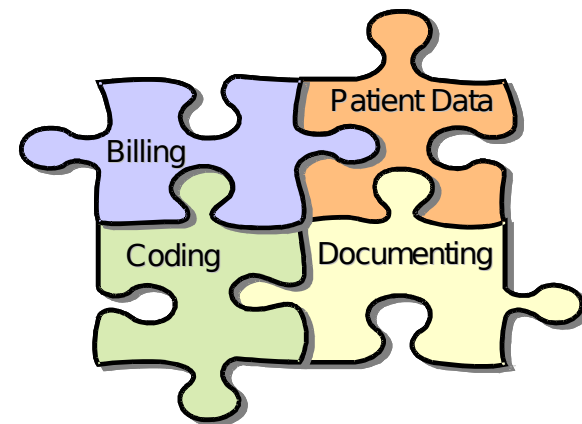
- DME equipment, devices, accessories, supplies, and repairs; prosthetics, orthotics; medical and surgical supplies.
- Medications
- Provider services
- Temporary Medicare codes
- Other items and services

HCPCS Codes: DME_



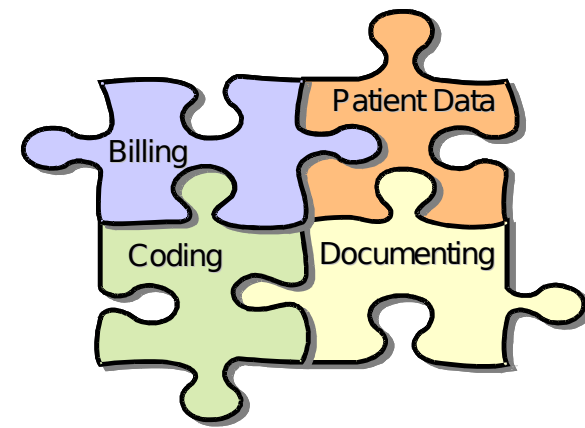
- Rental of portable liquid oxygen system – **E0434**
- Traction frame for lower extremity, attached to footboard – **E0870**
- Recording apnea monitor – **E0619**
- Adult transport chair – **E1038**

HCPCS Codes: DME



- Equipment and durable supplies will only be coded if the equipment/supply item is issued to the patient without expectation that the patient will return the item when no longer needed. For instance, if the patient is issued a C-PAP machine with the expectation the machine will be returned when it is no longer needed, the issue of the machine would not be coded. The personalized facemask would be issued with no expectation of return and so would be coded.

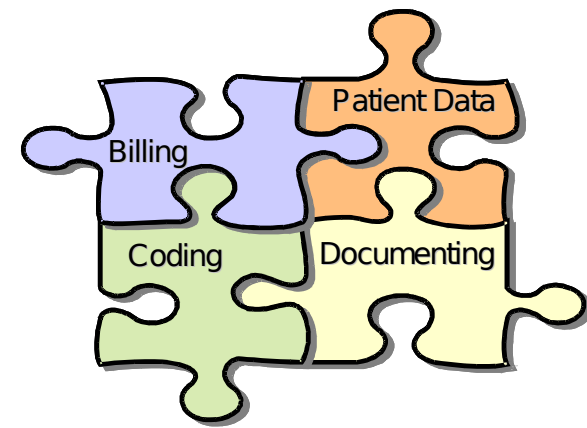
HCPCS Codes: DME Documentation Standards



The following documentation is necessary for DME items regardless of payer:

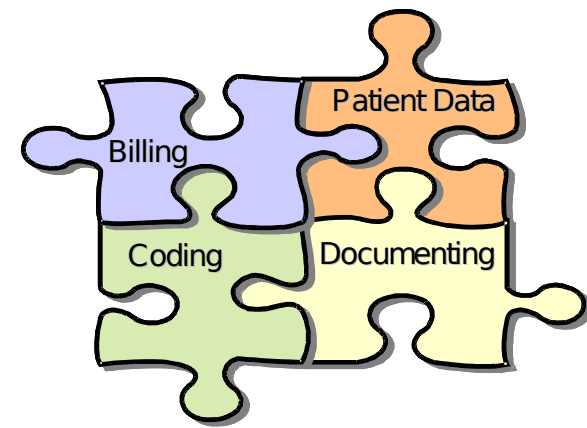
- Order for item should be signed and dated
- Order must be kept on file by the supplier
- Diagnosis establishing the medical necessity must be documented in the record

HCPCS Codes: DME Documentation Standards_



- If the medical necessity (as determined by the payer) cannot be established due to the nature of the patient's condition, injury, or illness, then the patient must sign a waiver before receiving the item.
- The waiver is called the advance beneficiary notice for Medicare patients. The document must be kept on file in case the Medicare DMERC, Medicaid agency, third-party payer, or managed care plan requests proof of the advance notice.

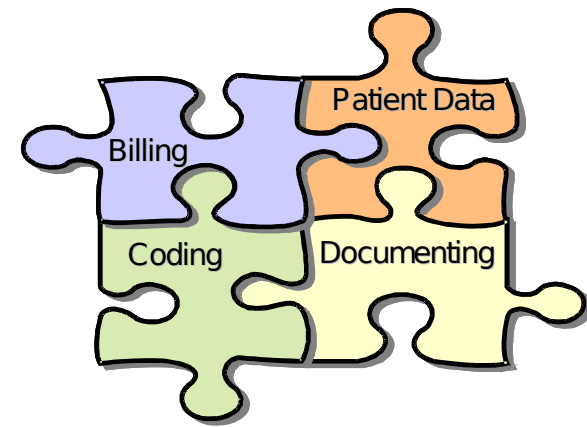
HCPCS Codes: Provider Orders for DME



Provider orders may take the form of:

- Clinical Record or Progress Note annotations
- Prescription forms
- Internally generated DME order forms
- Third-party payer forms for authorization and reimbursement

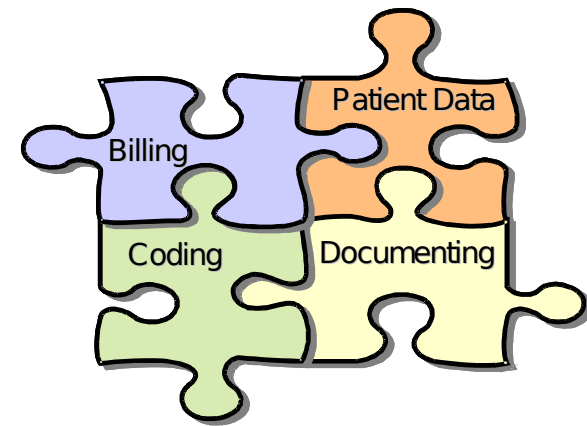
HCPCS Codes: Medications



These are drugs dispensed in the clinic, not the pharmacy.

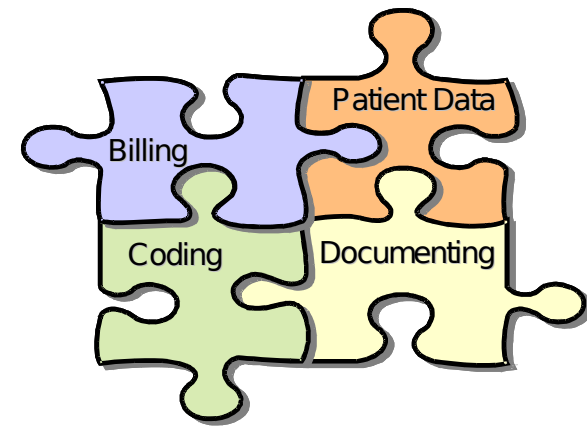
- Use HCPCS codes instead of CPT code 99070
- Describe medications by name and exact dosage
- May include the route of administration in the code description
- Code only in whole units
 - 250 mg given and describe in code = 1 unit
 - 400 mg given but described as 250 mg in code = 2 units coded
- Injection codes: identify actual substances

HCPCS Codes: J Codes are used to Identify the Drugs Administered



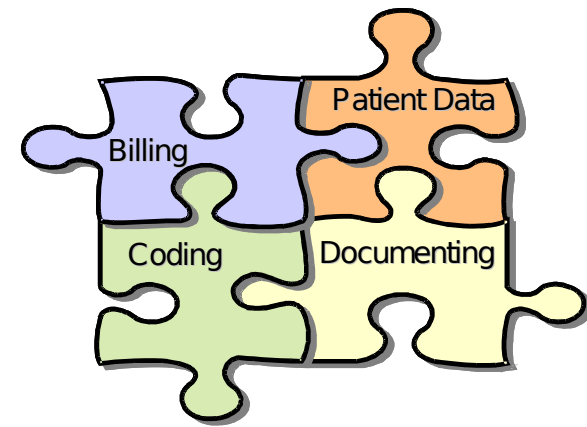
- J codes refer to drugs only by generic name.
- If a drug is known only by a brand or trade name, the index will direct to the generic name and associated J code by a cross-reference system within the Drug Table.
- J codes generally describe administration other than by oral method in the Route of Administration column.
- Medications will only be coded when the pharmaceutical/injectable is paid for directly from the clinic's funds and is not a routine supply item. If a drug is issued by the pharmacy to the patient, and the patient brings the drug to the clinic for administration, the drug will not be coded as the pharmacy was the service issuing the drug. Inpatient ward stock will not be coded as it is part of the institutional component and is part of the diagnosis related group (DRG).

HCPCS Codes: Route of Administration



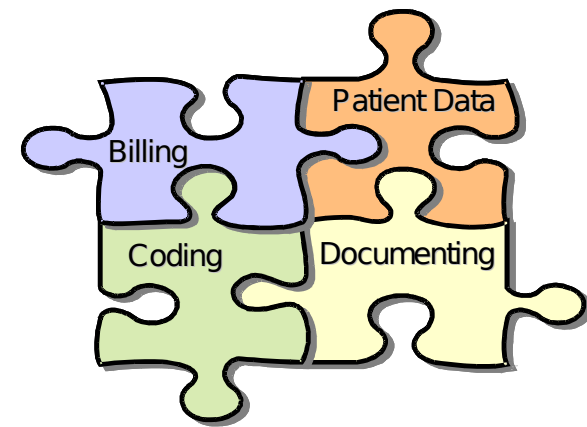
- IT – Intrathecal
- IV – Intravenous; includes gravity infusion, injections and timed pushes
- IM – Intramuscular
- SC – Subcutaneous
- INH – Inhalant solution
- VAR – Various routes
- OTH – Other routes
- When several routes of administration are listed, the first listing is the most common method.

HCPCS Codes: Supplies



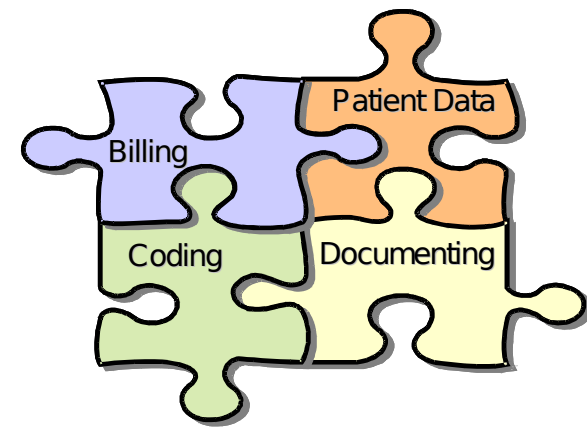
- Wheelchairs, hearing aid batteries and crutches
- Hearing aid, monaural, behind the ear - **V5060**
- Pair of full-length surgical stockings **A4510, A4510**
- Distilled water used with nebulizer, 1000ml - **A7018**
- Blood tubing, venous, for hemodialysis - **A4750**
- Urinary ostomy pouch with barrier attached - **A5071**

HCPCS Codes: Procedures/Services_



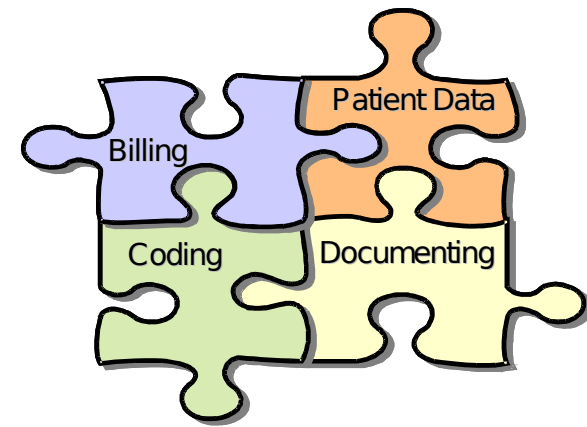
- Routine venipuncture for specimen collection – **G001**
- Trimming of dystrophic nails – **G0127**
- Diabetes self-management training, group session, per 30 minutes – **G0109**
- Colorectal cancer screening by barium enema -
G0120

HCPCS Codes: Ambulance



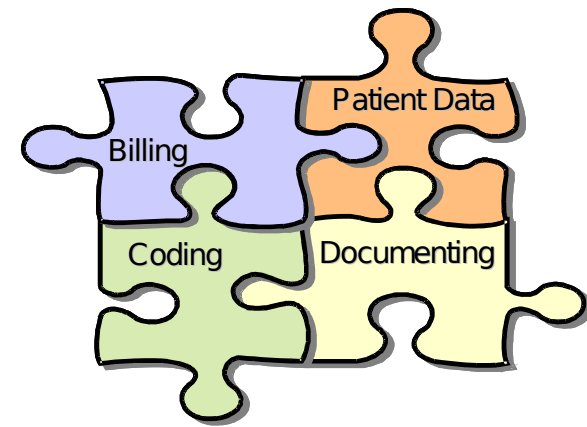
- Basic life support (BLS) ambulance services – **A0380**
- Neonatal transport- **A0225**
- Oxygen administered during advanced life support transport – **A0422**

Steps in HCPCS Code Assignment



- Look up the service or procedure in the index (usually found in the front of the HCPCS book)
- For drugs, look up the drug in the Table of Drugs at the back of the book, not in the Index
- Locate the suggested code(s) in the tabular, following any cross-referencing instructions
- Assign the appropriate code
- Determine whether a modifier is required to fully explain the service or supply
- Append modifier(s) if appropriate

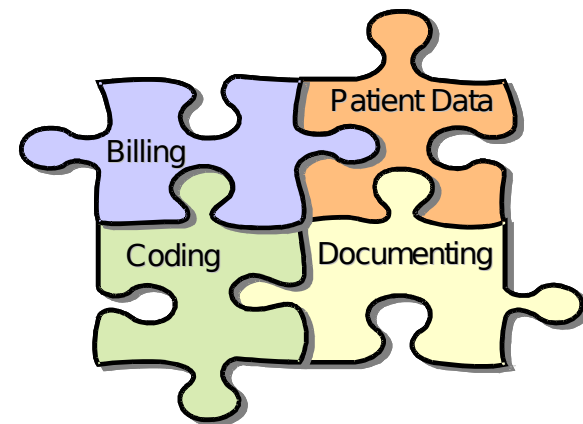
Steps in HCPCS Code Assignment: Index



Example

- *Enteral supply kit* is found under the entry:
- Enteral
 - Feeding supply kit, B4034 – B4036

Steps in HCPCS Code Assignment: Tabular



Heading

ENTERAL AND PARENTERAL
THERAPY *B4000-B999*

Subheading

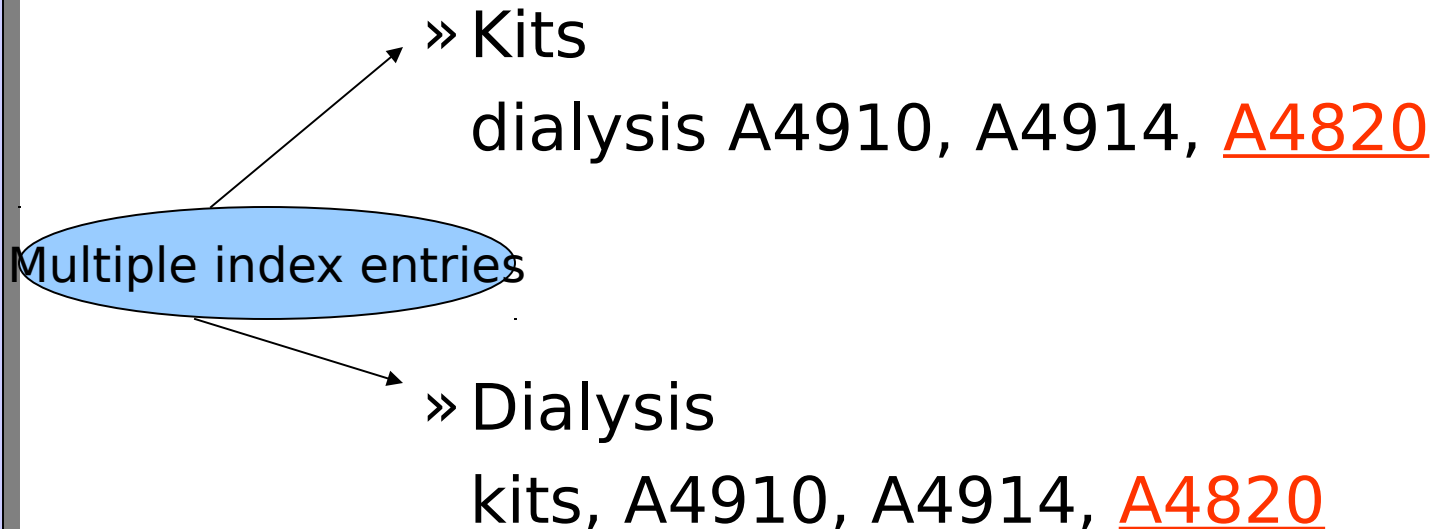
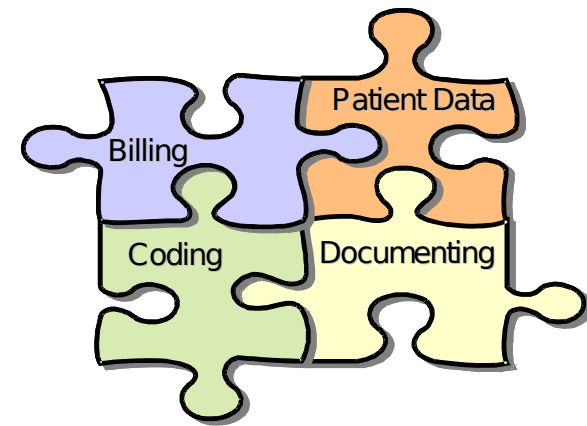
ENTERAL FORMULAE AND
ENTERAL MEDICAL SUPPLIES

HCPCS code

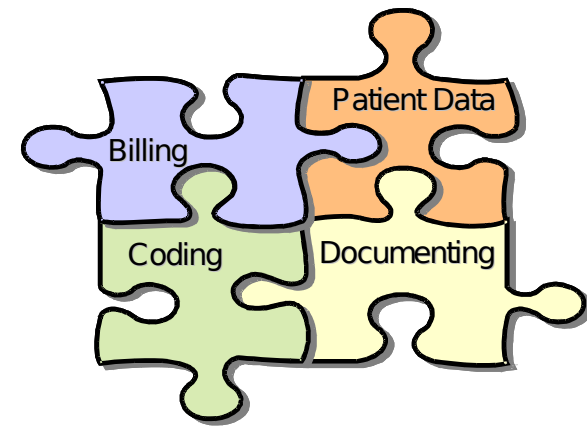
B4034 Enteral feeding supply
kit; syringe, per day

Description

Steps in HCPCS Code Assignment: Index

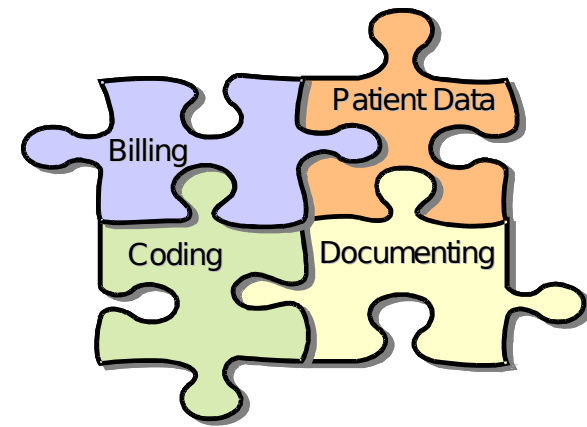


Steps in HCPCS Code Assignment: Table of Drugs



Drug Name	Amount	Route	Code
Diazepam	Up to 5 mg	IM, IV	J3360
Diclyclomin e (HCl)	Up to 20 mg	IM	J0500
Digoxin	Up to 0.5 mg	IM, IV	J1160

HCPCS Modifiers



- Modifiers permit greater specificity in relation to the main code
- Either two alpha characters or alphanumeric
- Modifiers may be used with any level of HCPCS code

Samples:

AA - Anesthesia services performed personally by anesthesiologist

E1 - Upper left eyelid

E2 - Lower left eyelid

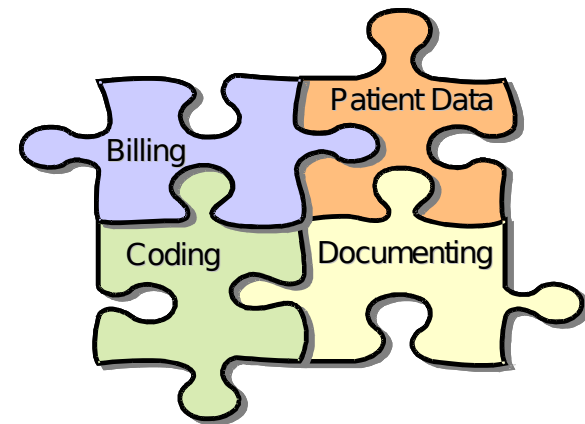
E3 - Upper right eyelid

E4 - Lower right eyelid

NU - New equipment

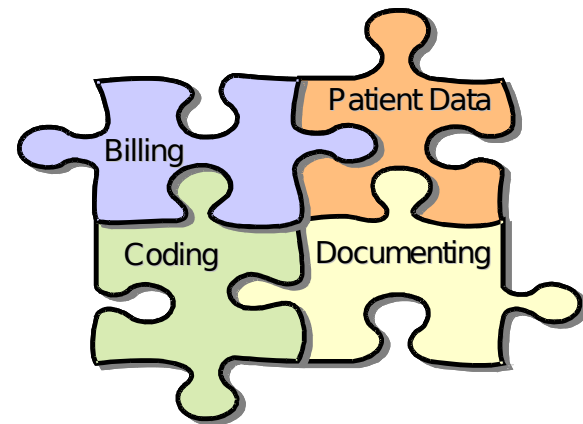
QC - Single channel monitoring

Coding Links



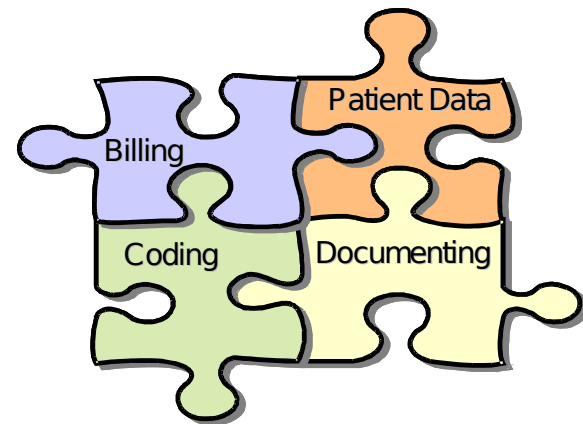
- **Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines, Unified Biostatistical Utility (UBU):**
<http://www.tricare.osd.mil/org/pae/ubu/default.htm>
- **Tricare Uniform Business Office (UBO) Business Rules:**
http://www.tricare.osd.mil/ebc/rm_home/ubo_documents_policy_guidance.cfm
- **ICD-9-CM: National Center for Health Statistics (NCHS):**
<http://www.cdc.gov/nchs/icd9.htm>
- **CPT: American Medical Association:** <http://www.ama-assn.org>
- **HCPCS/CMS:** <http://cms.hhs.gov/medicare/hcpcs/default.asp>
- **American Hospital Association (AHA):** <http://www.aha.org/aha/index.jsp>

Summary

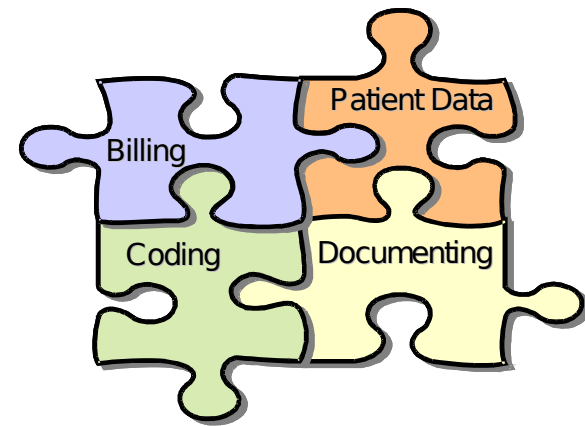


- What are HCPCS codes?
- When are HCPCS codes used?
- How are HCPCS codes used?

Questions?

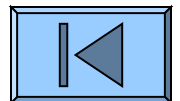


magowen@us.med.navy.mil

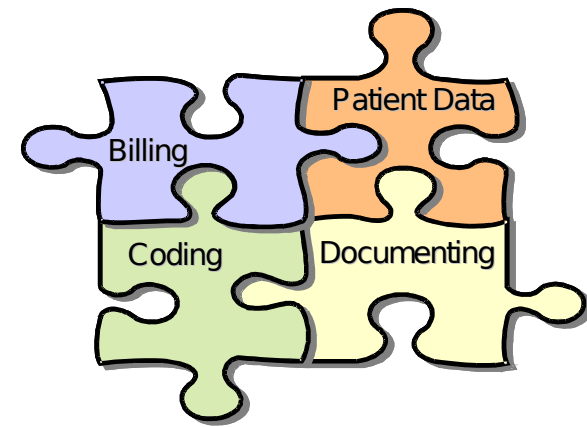


Inpatient Professional Services Coding

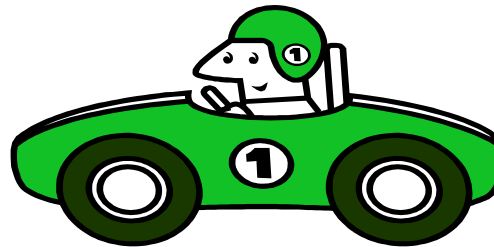
Cindy Pierson, RHIA
Tuesday, 17 May 05
Track 1, UBU Basic



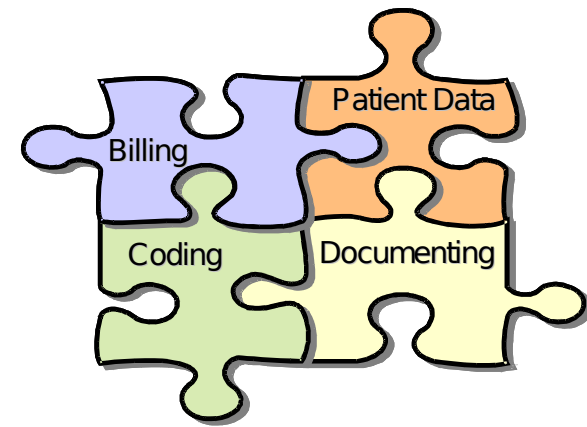
Objectives



- To provide guidance on inpatient professional services coding
- Know impacts and issues of reporting

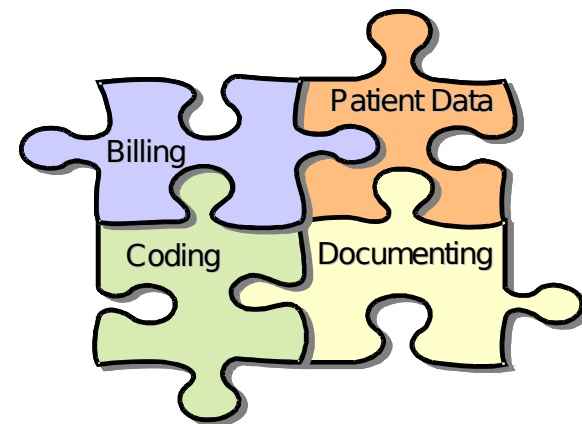


History



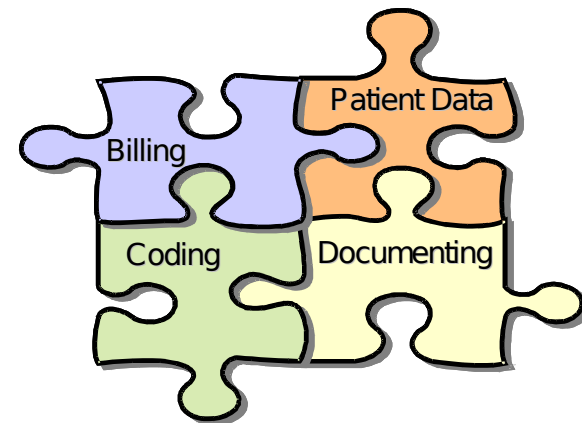
- **TMA Memo dated October 02**
- **A strategic initiative to align MHS with civilian sector**
- **a.k.a. IBWA = Industry-Based Workload Alignment**
- **Precursor to Inpatient Itemized Billing**
- **Module is currently available in CHCS**

Definitions



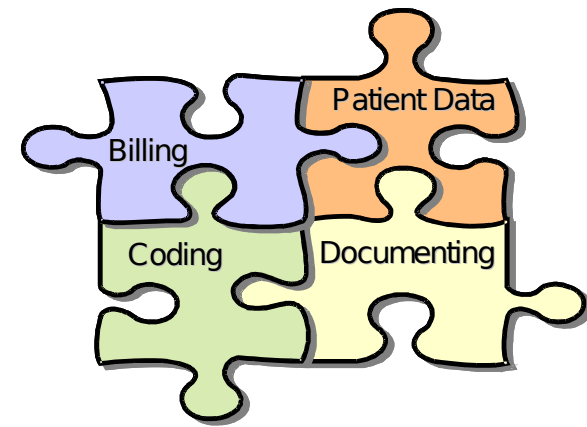
- **Institutional Services.** Healthcare services provided by non-privileged providers/staff, interns, residents, and fellows. Includes resources associated with equipment, facilities, utilities, and supplies, all of which are utilized or consumed during a patient's encounter with the healthcare system.
- **Professional Services.** Healthcare services provided directly to the patient by a privileged provider. Excludes services provided by interns, residents, fellows and any Graduate Medical Education (GME) staff.

Professional Services



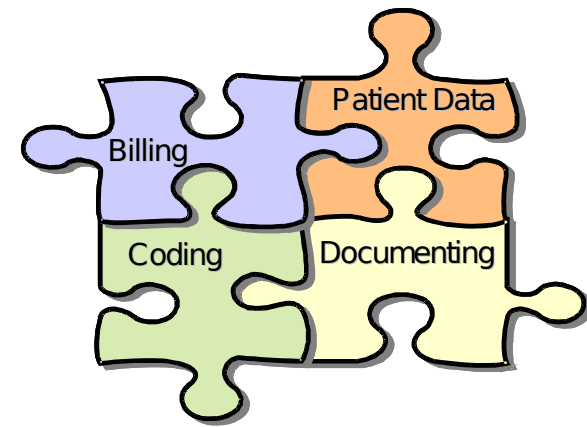
- **All inpatient professional services report**
 - **Attending/consulting providers document patient encounters in the inpatient record**
 - **Interns, residents and fellows will not be the sole provider recorded on an inpatient SADR. If an attending is not present during the encounter, the inpatient SADR is cancelled**
- **Workload to be captured**
 - **Inpatient care within MTFs**
 - **Professional services provided at civilian facilities and VA facilities**

Rounds Appointment Type



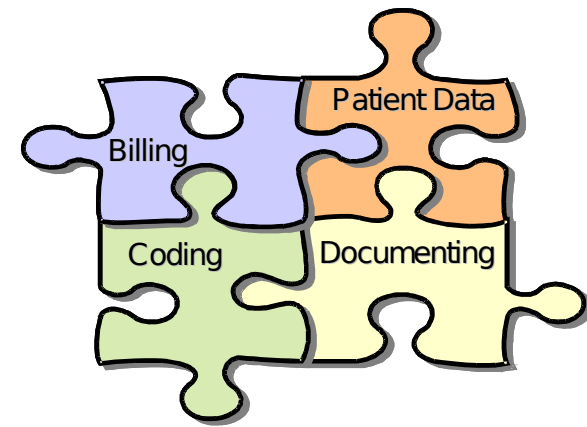
- **New appointment type -Rounds (RNDS)**
 - **Patient's admission to the MTF - appointment created in CHCS for admitting/attending provider**
 - **Subsequent RNDS appointments automatically created at the census hour for attending physician**
 - **RNDS appointment created upon inpatient transfer (via ADT); includes change in MEPRS**
 - **No "future" booking of anticipated RNDS appointments is allowed**

Business Rules (cont'd)



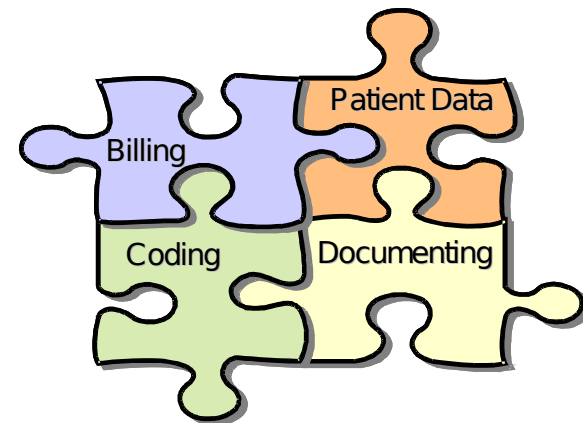
- **Inpatient E&M services limited to a defined code set**
- **Up to 2 additional providers may be listed on the SADR with additional E&M and CPT codes**
- **New disposition codes specific to RNDS appointment**
 - **Transfers to other hospital, SNF, clinic service**
 - **Continued stay**
 - **Left AMA**
 - **Discharge to home**
 - **Expired**

What is coded?



- **Code the record each time rounds are made by the attending physician (not resident)**
 - **Documentation must support level of care provided**
 - **Use of templates, worksheets, or super bills to capture E&M services**
- **Multiple providers in the Same Service**
 - **Last provider documents services provided for that calendar day**
 - **List others as additional providers**

ADM Screen Changes



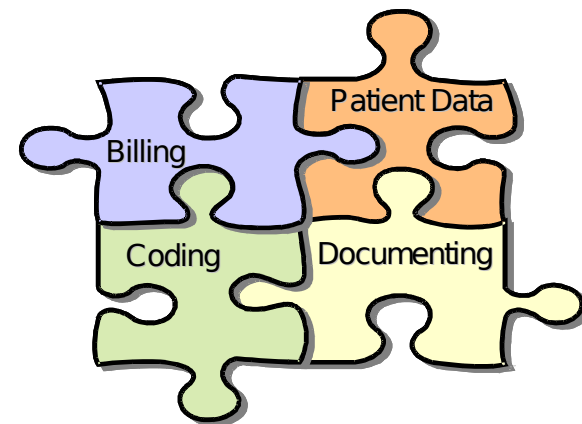
GRANT, CARY R		ADM Patient Encounter 20/000-00-0001		AGE: 24y	
Appt Date/Time : 06 Oct 1998@0001		Type: RNDS		Status: KEPT	
Clinic: IBWA Clinic XXXX				MEPRS: AAAA	
In/Outpatient: Inpatient		APV: No		Work Related: No	
Appt Provider: WELBY, MARCUS		Injury Date:		Role:	
2nd Provider #1:				Role:	
2nd Provider #2:					
Disposition: CONTINUED STAY					
=====					
ICD-9	Dx Description			Priority	

333.1	TREMOR NEC			1	

Chief Complaint: 333.1		TREMOR NEC			

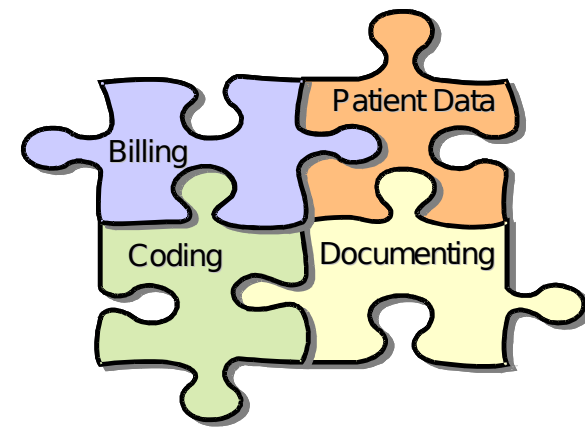
Edit	Icd-9	e&M	Cpt/hcpcs	Admin Code	File View mail cUo eXit
s					

Manual Creation of RNDS Appointment



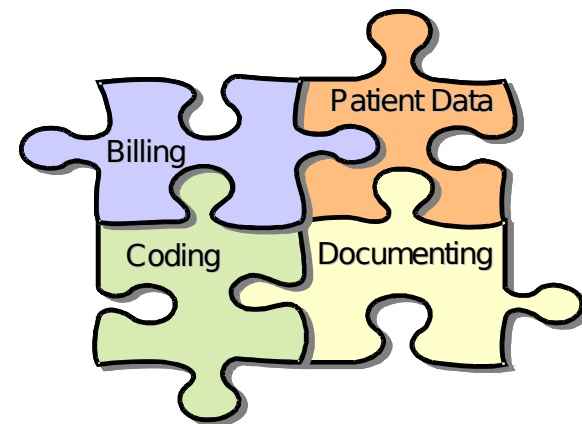
- **Two common reasons for creating a RNDS appointment manually**
 - **When transfer is not precipitated by a consult or the consult was done on a different day than the transfer, RNDs encounter will have to be initiated using the manual feature (gaining clinical service will have to manually generate the new RNDS ADM encounter)**
 - **To record a procedure done by another provider within the same clinical service**

Initial Day of Care



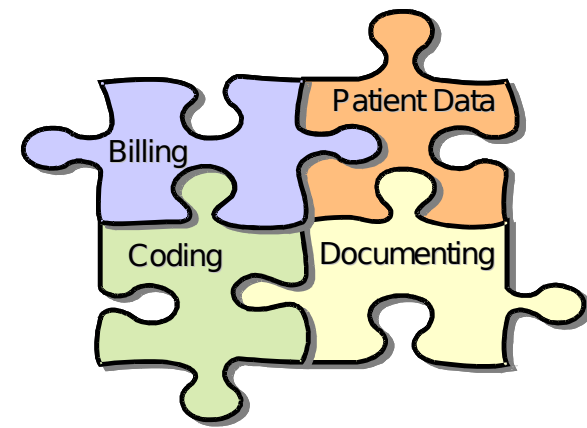
- **Code for the initial day of hospital care**
 - **Combine all E&M services provided by same physician on the same date, no matter where services are performed**
 - **Use codes 99221-99223**
 - **Perform detailed/comprehensive H&P several days prior to admission; on day of admission a lesser H&P is done**
 - **Code to the lower H&P**
 - **Other physicians (other specialties)-Consult Code**

Initial Day of Care-- cont



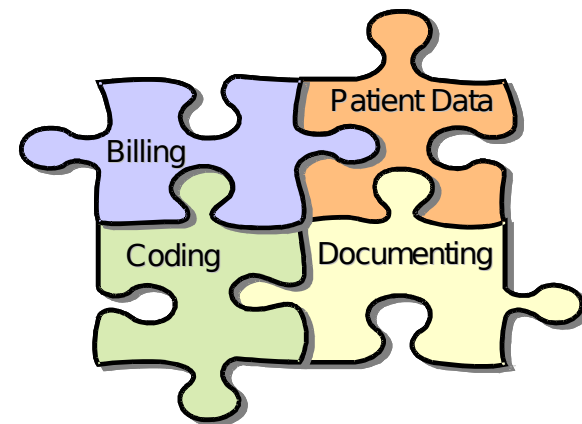
- **Patient admitted one day; provider sees patient the next work day**
 - **Admission history & physical reported on 2nd day**
 - **Higher levels of admission require complete ROS**
- **Code for additional E&M services on Initial Day of Hospital Care: 2nd or 3rd E&M with the appropriate rounds code**

Subsequent Days of Care



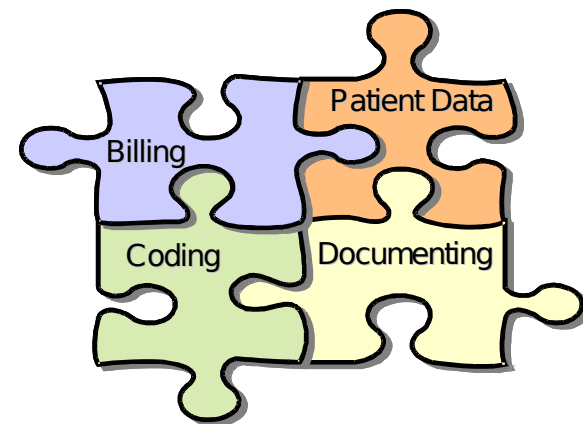
- **Rounds on subsequent days of hospital care**
 - **99499 Subsequent days for patient admitted for surgical procedure**
 - **99231 Subsequent hospital care**
 - **99433 Subsequent newborn hospital care**
 - **Include reviewing diagnostic studies and changes in the patient status**

Subsequent Care Days



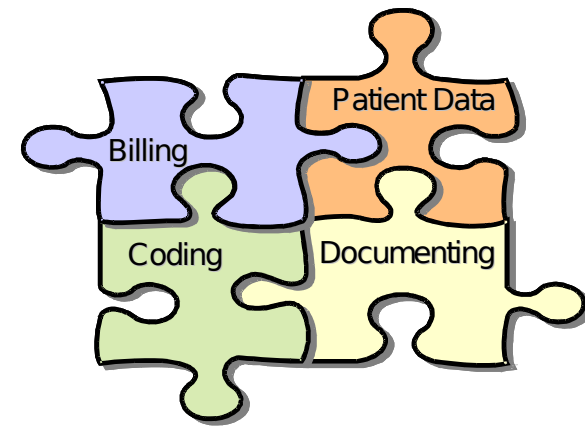
- **Subsequent care - Post Surgical**
 - For routine post surgical privileged provider care, code the round with E/M 99499 and CPT 99024.
 - For post surgical complications, code the complication care with the applicable “subsequent care” code AND code the routine portion of the follow up care with the CPT 99024
- **Additional E/M on same day as Subsequent Care Codes**
 - -Critical care services - 99291/2
 - -Prolonged inpatient face-to-face - 99356/7
 - -Prolonged non-face-to-face - 99358/9 - 99360

Subsequent Care Days

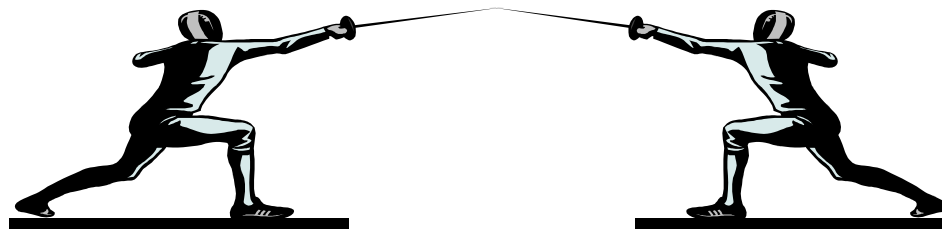


- **Additional E&M services**
 - **Critical care 99291/2**
 - **Subsequent pediatric critical care 99294**
 - **Subsequent neonatal critical care 99296**
 - **Subsequent intensive care, very low birth weight (<1500 grams) 99298**
 - **Subsequent intensive care, very low birth weight (1500-2500 grams) 99299**
 - **Prolonged Inpatient face-to-face 99356/7**
 - **Prolonged inpatient non face-to-face 99358/9/60**

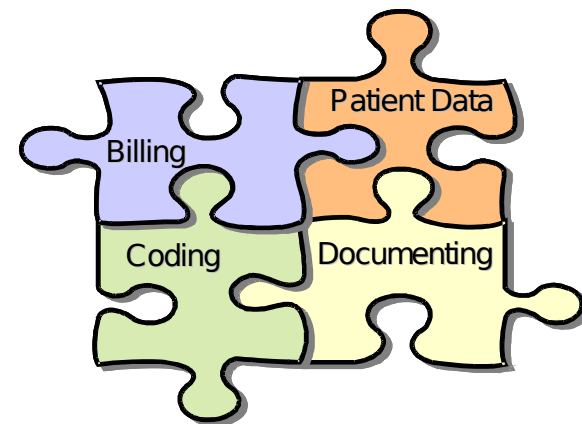
Same Day Dispositions



- **Admitted and Discharged on same Date**
 - **Code to 99234-99236**
 - **Do not use separate codes for identifying admission and discharge services**

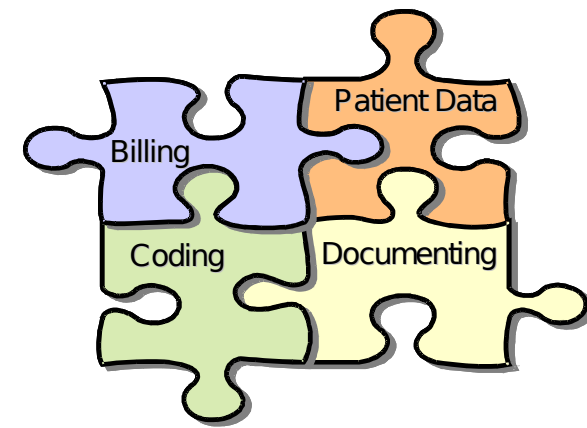


RNDS Discharge Day



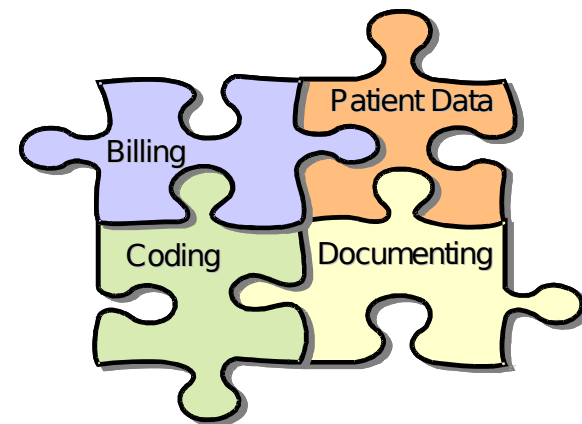
- **Rounds for discharge day of care**
 - **Discharge services including Newborns 99238/9**
 - **Same day of admission and discharge 99435**
 - **Discharge for surgical procedure patient without complications 99499**
 - **Code other E&M services provided on discharge**
 - **Critical care**
 - **Prolonged care**
 - **Code the attending provider who discharged pt**

Inpatient Consultations



- **Inpatient Consults**
 - **Request for services from different MEPR clinic**
 - **Use the standard appointment type—SPEC**
 - **“Is this related to the inpatient stay?” “No”**
 - **Workload reported to “B” MEPR code**
 - **Consultation from same service**
 - **“Is this related to the inpatient stay?” “Yes”**
 - **Workload reported to “A” MEPR code**
 - **Interpretation: “Are you from the attending service or is the patient to be transferred to your service?”**

Inpatient Consultations



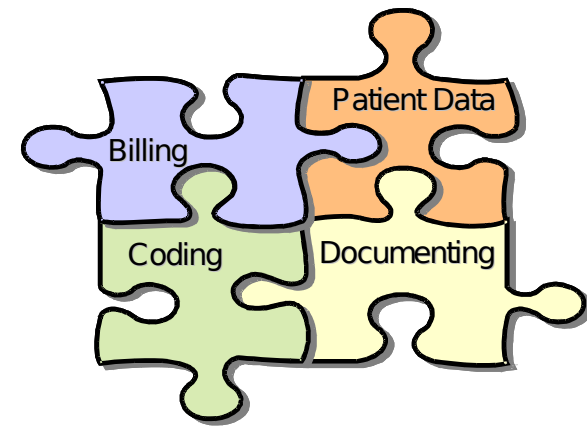
- **Initial Inpatient Consult**

- Provides initial opinion or gives advice regarding the services of a specific problem at the request of the attending physician
- Diagnostic and therapeutic Services may be started
- Written report sent to requesting provider
- Use codes 99251-99255 (use only once during hospitalization by the specialty requested)

- **Follow-up Consult**

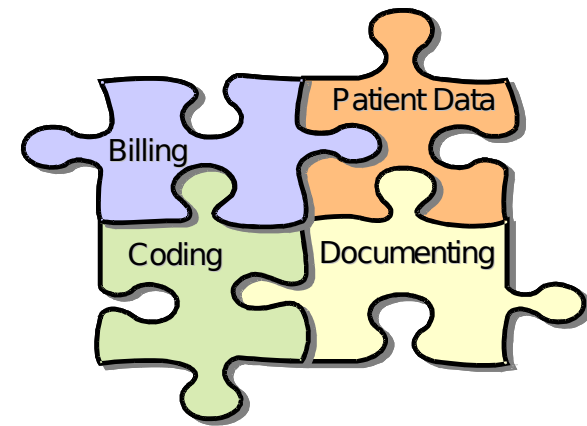
- Consultant asked to see the patient again for an opinion or advice regarding same or new problem

Inpatient Consult (cont'd)



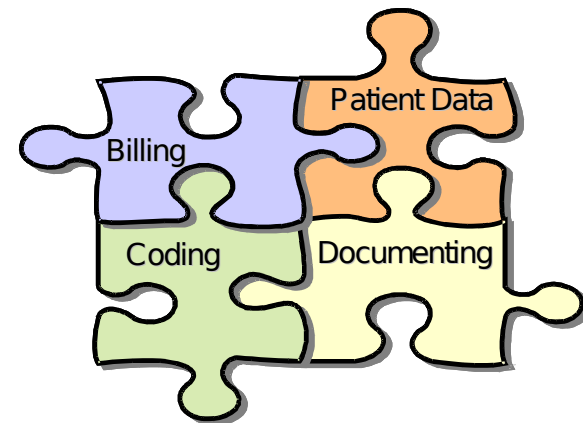
- **Inpatient Consult - Subsequent Hospital Care**
 - Both the attending and consultant assume responsibility (for different aspects of care) for some or all inpatient care
- **Confirmatory Consult**
 - Patient, family member, insurance company may request consultation services
 - Use code **99271-99275**

Prolonged Care



- **Prolonged Care**
 - **Document reason why and the time spent**
 - **May be face-to-face or non face-to-face**
 - **Reported after direct patient care**
 - **Codes 99358/9**
 - **Total time for prolonged service must exceed basic service by at least 30 minutes**
 - **Non face-to-face is coded only once per date**

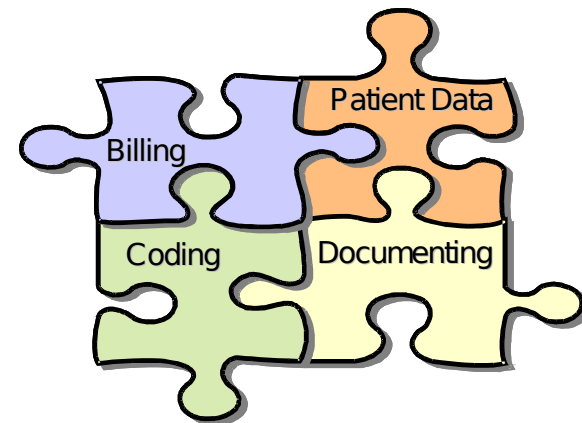
Critical Care Services



- **Critical Care Services**
 - **Provided to unstable, critically ill or injured patients who require constant physician attendance (respiratory failure, post-op complications, etc)**
 - **Not always in critical care area like ICU or the ER**
 - **Use codes 99291-99292**



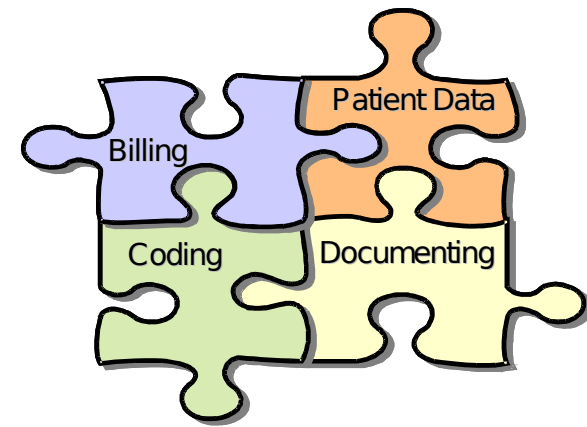
Critical Care Services



- **Critical Care Services-continued**
 - **First hour critical care on a given date - code 99291**
 - **Each additional 30 minutes beyond the first hour - 99292**
 - **Use the units of service to show each additional 30 minutes**



Standby Services

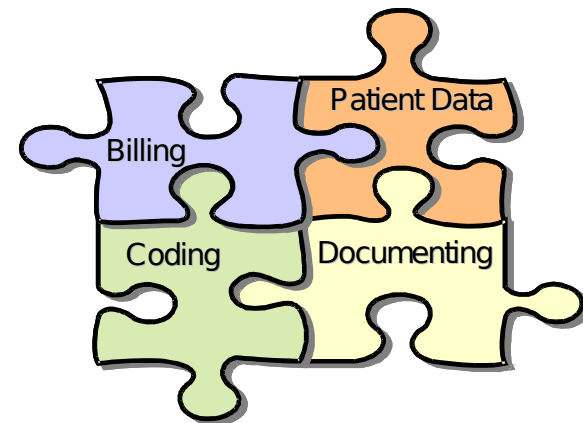


Physician Standby Services

- Report codes 99360 or 99436 (for attendance during delivery)
- At the request of another provider
- Requested physician cannot be doing other services or care during the standby services
- Provided in 30 minute increment

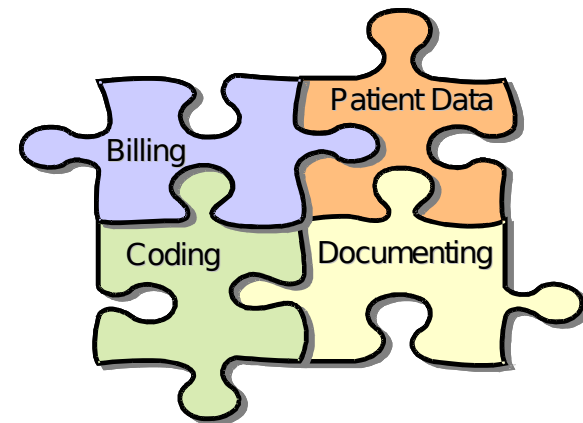


How Do I Code.....?



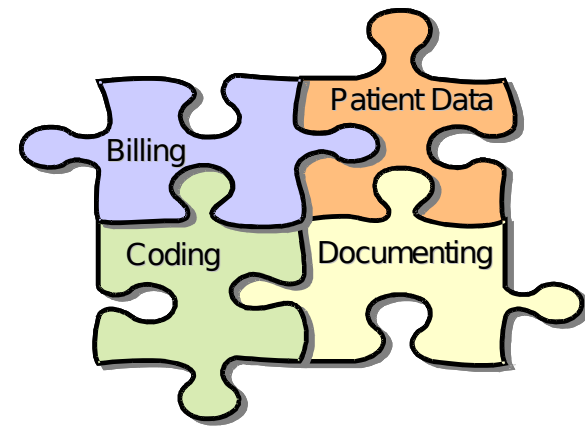
- **Non-surgical Patients - Code Initial Admission E/M:**
 - Initial hospital care codes - 99221-99223
 - Inpatient care, admitted and discharged same day - 99234-99236
 - Initial pediatric critical care - 99293
 - Initial neonatal intensive care - 99295
 - Initial neonatal services in hosp or birthing room - 99431
 - Initial neonatal services not hosp or birthing room (e.g., at home) - 99432
 - Initial and discharge neonatal services - 99435

How Do I Code.....?



- **Surgical Patients - Code**
 - **Admission for surgical procedure - Once a decision for surgery made for a procedure with a 90-day follow-up, the professional services for the day prior, the day of the procedure, and all routine follow-up are included in procedure code**
 - **For surgical admissions, when surgery is not the day of or the day after admission, use the appropriate admission E&M code**
 - **For surgical admissions when surgery is the day of admission or day after admission, use 99499 as the E&M code**

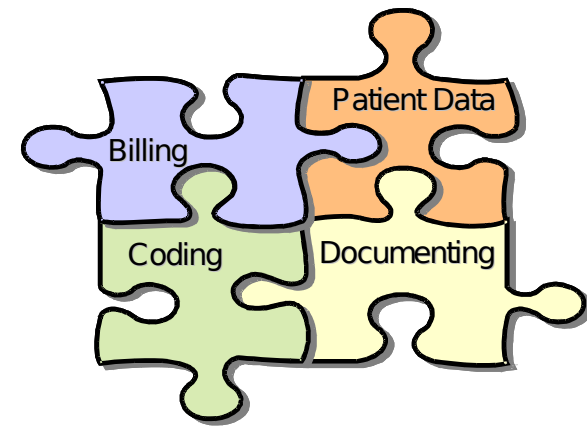
Other Professional Services



- **Attendance at delivery**
 - (requested by delivering physician)**99436**
- **Critical care services - 99291/2**
- **Newborn resuscitation - 99440**
- **Prolonged inpatient face-to-face - 99356/7**
- **Prolonged non-face-to-face - 99358/99360**



Discharge Day

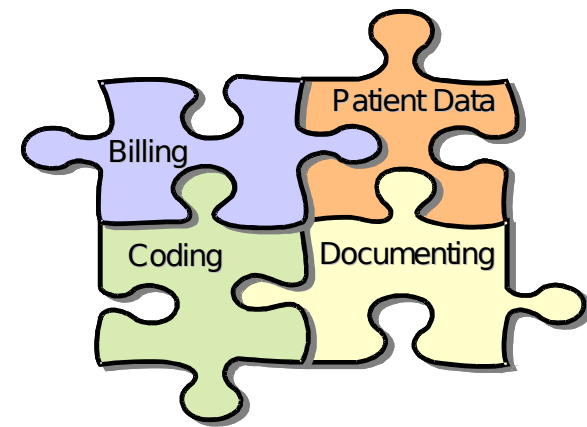


- **Rounds for Discharge Day**
 - **Discharge services (to include newborn)**
 - **99238/9**
 - **Based on time - be sure to have documentation of 30 minutes or fewer, OR more than 30 minutes**
 - **Discharge services (admission and discharge same date) - 99435**
 - **Discharge for surgical procedure patient without complications - 99499**

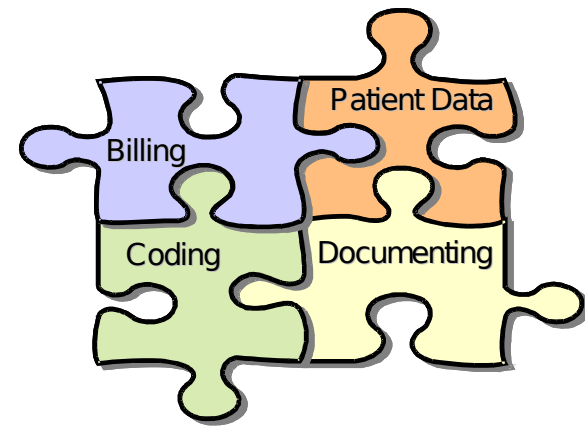
Professional Inpatient Services

• For surgical patients -

- If admitted the day prior or day of surgery, routine services (“has anything changed since we did the physical two weeks ago”) - code E/M of 99499 because ROUTINE E/M included in the surgical code
- All routine POST OPERATIVE care is coded with E/M of 99499 and CPT of 99024.
- Code complications, and rounds prior to 24 hours before the surgery based on history/exam/decision making using appropriate admission, subsequent, or discharge day codes

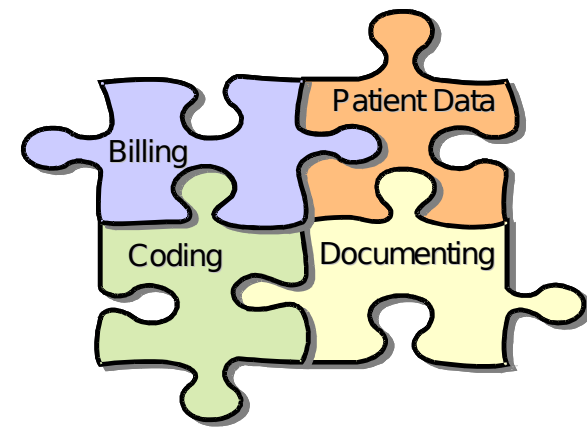


Inpatient Consultation Services



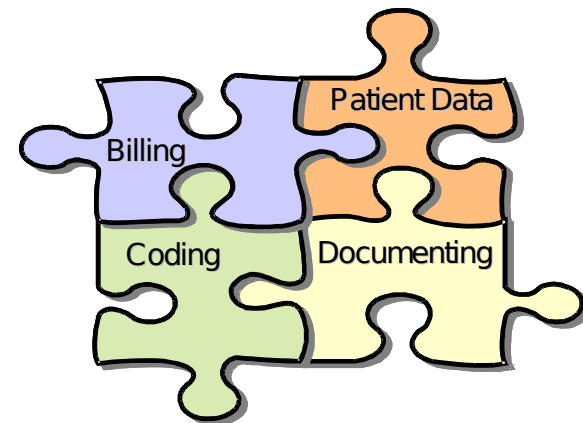
- **Should map to the B MEPRS as they are not the attending**
- **Use the appropriate “INPATIENT” consult codes in the B MEPRS**
- **BOTTOM LINE: Do not expect to see consults in the A MEPRS**

Life Skills/Mental Health



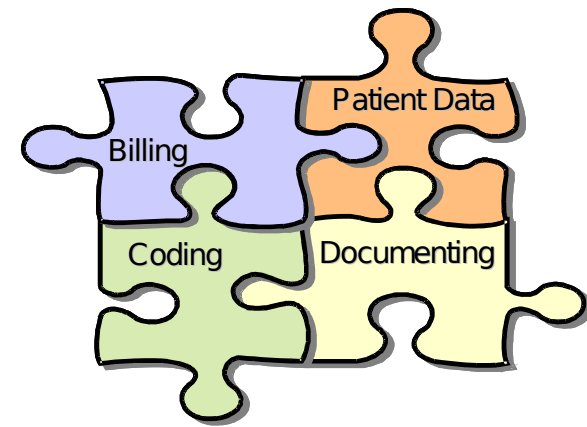
- If a mental health privileged provider does therapy, for an inpatient, the 908xx codes without E&M services apply
- If a mental health privileged provider does an E/M and therapy for an inpatient, the 908xx codes with E&M services apply
- If mental health provider does an E/M without therapy, use the inpatient admission/subsequent care/discharge E/Ms

Physical Therapy



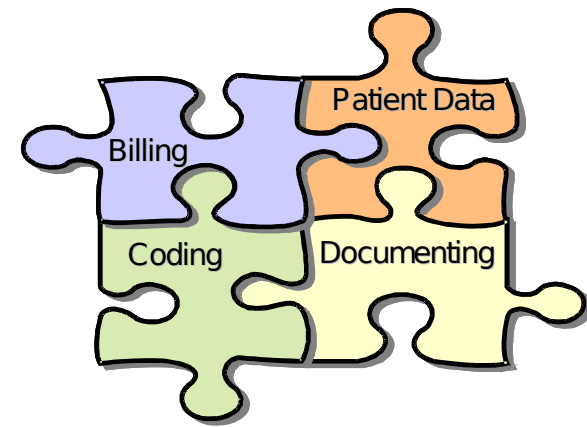
- **Only MEPRS used by Physical Therapy is BLAx**
 - **If you collect your time in one MEPRS, you must collect your workload there also**
 - **Time spent with patient is necessary for many Physical Therapy codes - be sure it is documented**
 - **BOTTOM LINE: Physical therapy is collected in BLAx MEPRS, not in an “A” MEPRS**

Diagnosis Coding



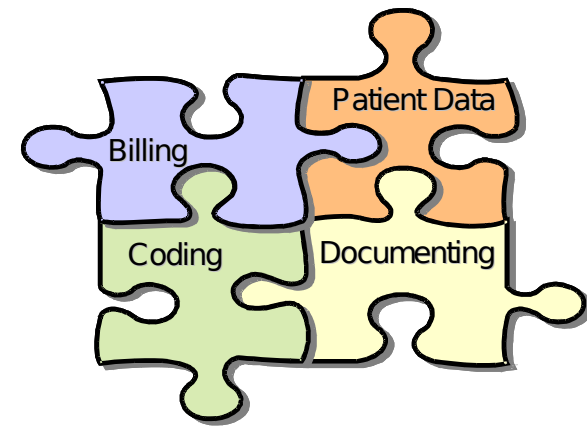
- **Code using the **AMBULATORY** diagnosis coding rules**
 - **Code each day based on the E/M, not on the discharge dx**
 - **Code to highest level known**
 - **Don't code "Lumbar disc vs lumbago vs sciatica"**
 - **Don't code suspected, rule out, probable...**

Diagnosis Coding



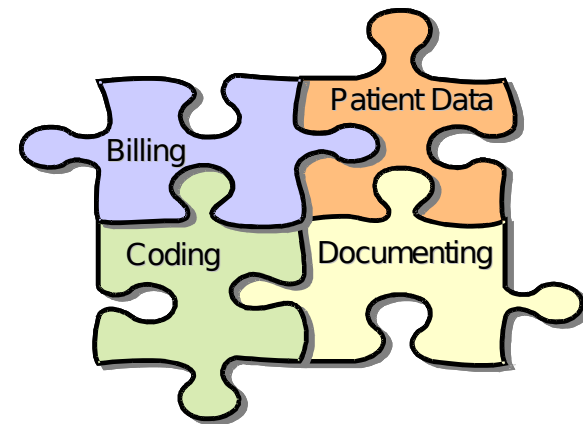
- **Code the symptom or diagnosis that best explains why a test/study/procedure was done,**
 - **Comes in with chest pain. Does lab tests. Determines not MI, but it is GERD.**
 - 1. GERD**
 - 2. Chest pain**
 - **Match 2. Chest pain to the tests/studies/procedures**

Providers' Inpatient Documentation - Admission



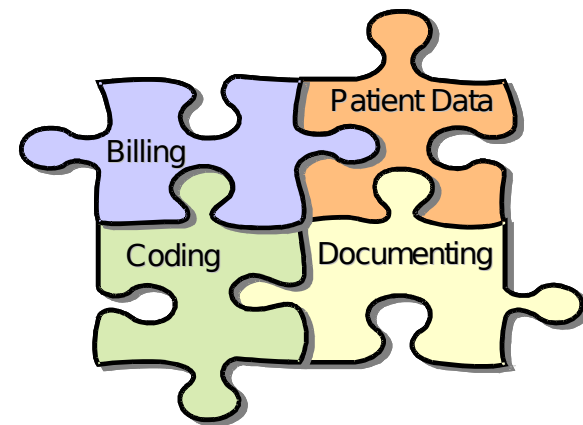
- **Admission day, needs documentation of history, exam and decision making**
- **ALL evaluation and management (E/M) care for that day, by providers in admitting service, no matter where provided (e.g., clinic, observation, telephone) is included in the initial hospitalization E/M**

Providers' Inpatient Documentation



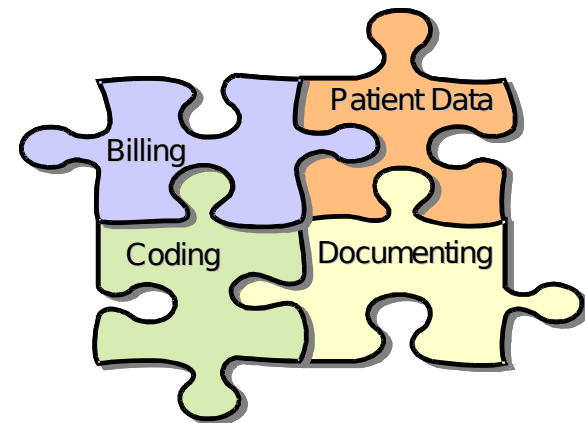
- **Capture underlying conditions/diseases that impact the care, state if they are chronic/acute and if they are stable or if an exacerbation**
- **If admitted for a suspected/possible/probable - need to state what symptoms caused the working diagnosis**
- **For burns, need percent of body with 1st, 2nd, and 3rd degree**
- **MI - are you treating an MI that took place in the past 8 weeks**

Underlying/Contributing Conditions



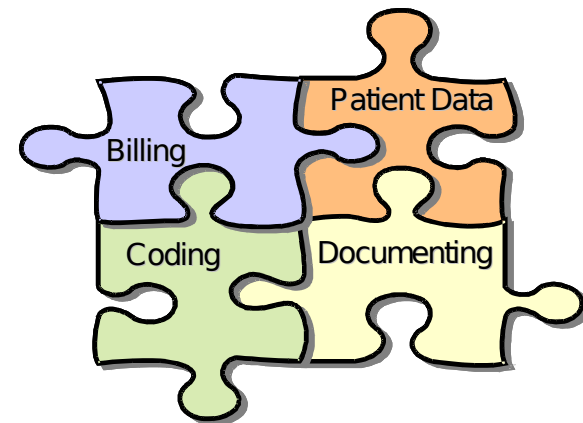
- **Hypertension, pre-hypertension**
- **Smoker**
- **Diabetic, pre-diabetic**
- **Depression**
- **Allergies (medication, food, seasonal)**
- **Family history of coronary artery disease, various cancers**
- **Allergies to drugs (e.g., PCN)**

Diagnosis Coding Subsequent Days



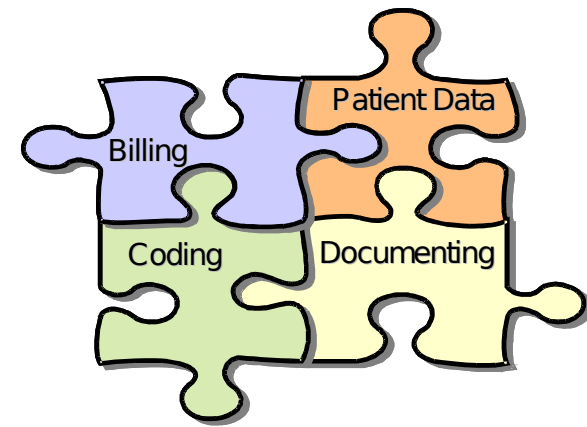
- **Assessment of the patient's response to treatment**
 - **Response to medications**
 - **Response to treatment for each problem assessed during the rounds, is the condition improving, worsening, stable?**
 - **Complications (unexpected at this point in the care)**
 - **New problems**

Surgical Coding



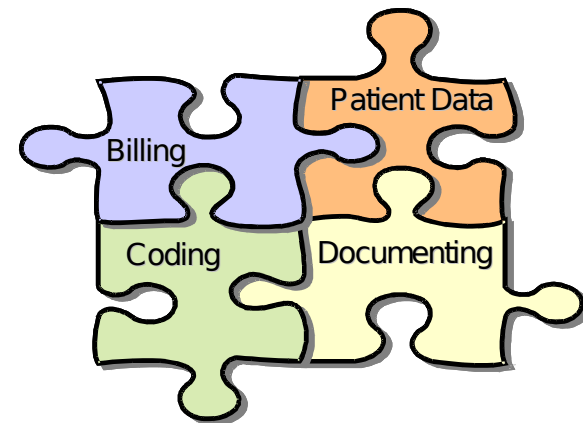
- **E/M day prior to major surgery included in major surgery code unless**
 - **Decision for surgery made during that E/M (modifier -57)**
- **Uncomplicated routine post surgical E/M included in procedure**
 - **Use CPT 99024 for uncomplicated post op visits**

Surgical Coding



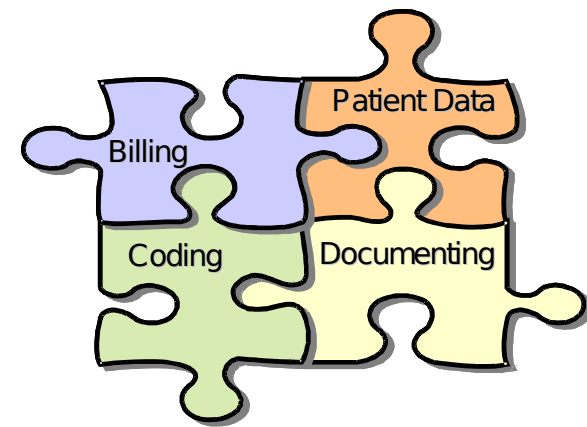
- **Code any complications to surgery (supported by documentation)**
 - **Delayed healing**
 - **Delayed treatment**
 - **Infections**
 - **Late effect**
 - **Adverse reaction**

Pregnancy/Delivery Coding



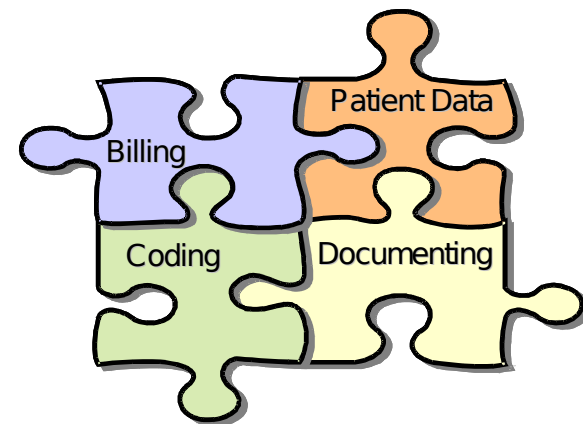
- **Can only code attendance at delivery if requested by delivering provider**
- **Can not code both 99436-attendance at delivery and 99440-newborn resuscitation, for same encounter**
- **59050/1 - Fetal monitoring during labor by consulting physician (e.g., non-attending physician) with written report; be careful, commonly miscoded**

Impacts



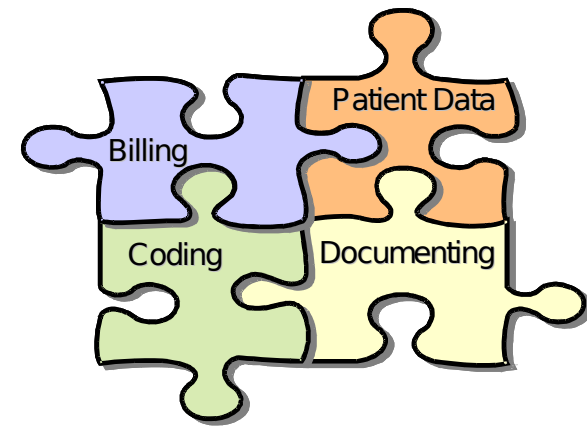
- **Each day patient is hospitalized, a new appointment (RNDS) will automatically be created in CHCS**
- **Concurrently, or at end of the hospitalization, inpatient institutional coders will review the record, code professional services, and associate them with the RNDS appts**
- **RNDS data will be transmitted with SADR data records; institutional (hospital) services will continue to be coded “as is” and will be transmitted with the SIDR records**

Impact



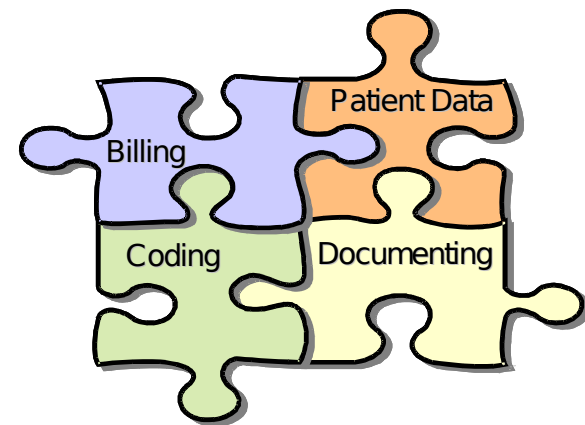
- **Professional Services at Civilian Hospital**
 - **Report in FCCx MEPR**
 - **Walk-in appointment status**
 - **Use Inpatient Services E&M codes**
 - **Cannot use RNDS appointments or disposition types**

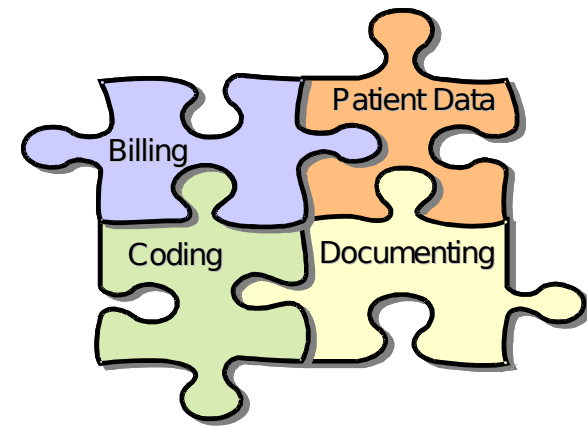
Issues



- **Metrics**
 - **SADR data reported to TMA data warehouse (M2)**
 - **RNDS appointments/Beddays**
 - **Excludes Bassinet days**
 - **Bedday count excludes Disposition Day**
 - **Percentages may be greater than 100%**
- **No “RNDS” appointment created after 30 days**
- **No “RNDS” appointment to capture professional services at civilian/other federal hospitals**

Questions?

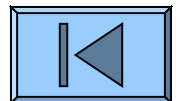




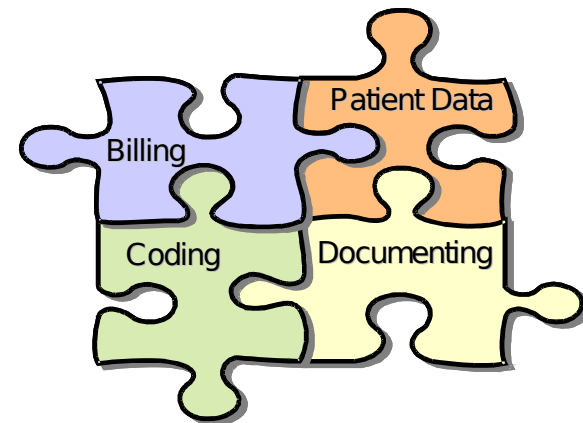
Institutional Coding

The Standard Inpatient Data Record (SIDR)

Cindy Pierson
17 May 05
Track 1 UBU 1510-1600

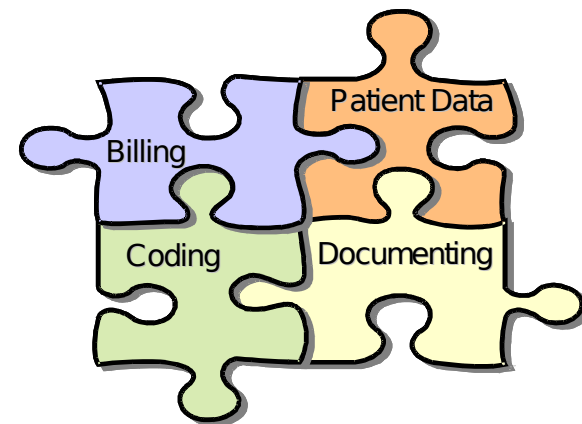


Why SIDR?



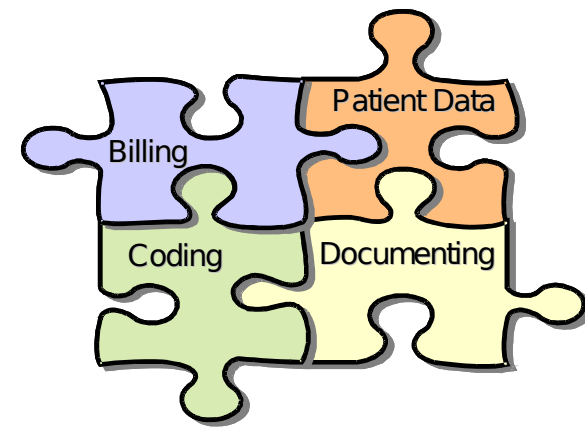
- **Standardize military medical records (A/N/AF)**
- **Capture the Institutional Cost (Diagnosis Related Groups - DRG)**
 - **All Inpatients at Military Treatment Facilities (MTFs)**
 - **All Active Duty Inpatients in Non-Fed Hospitals (absent sick, non-federal hospitalizations)**
 - **Carded for Record Only (CRO - Other, DOA, ERD)**
 - **Army - CRO/DOA-ERD for active duty**
 - **Air Force - collect in SADR (Standard Ambulatory Data Record)**

Standard Inpatient Data Record



- **International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1, 2, & 3 (procedures)**
- **Companion Guidelines**
 - **DoD Disease and Procedure Classification, ICD-9-CM Coding Guidelines (Effective 1 Jan 89, last revised 1 Jul 98)**
 - **ICD-9-CM Official Guidelines for Coding and Reporting - The Centers for Medicare and Medicaid Services (CMS) & the National Center for Health Statistics (NCHS) (Effective 1 Apr 05)**
 - **AHA *Coding Clinic***
 - **Joint Commission**

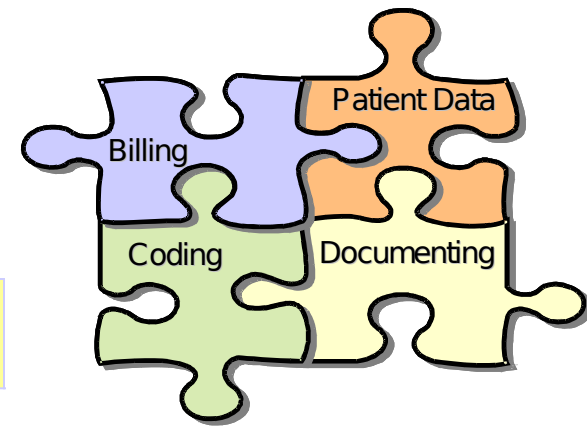
SIDR Implementation



- **Army:**
 - AR 40-400, Patient Administration
 - AR 40-66, Medical Record Administration and Health Care Documentation
- **Navy:** **NAVMAN MED P-117 ????**
- **Air Force:**
 - AFI 41-210 Patient Administration Functions
 - AFMAN 37-139 (record retirement/disposition)
- **Service Level Support**
 - **Army:** PASBA (Patient Administration Systems & Biostatistics Activity)
 - **Air Force:** PHSD (Population Health Support Division)
 - **Navy:** BUMED ??

The Golden Rules

Joint Commission on Accreditation of Healthcare Organizations



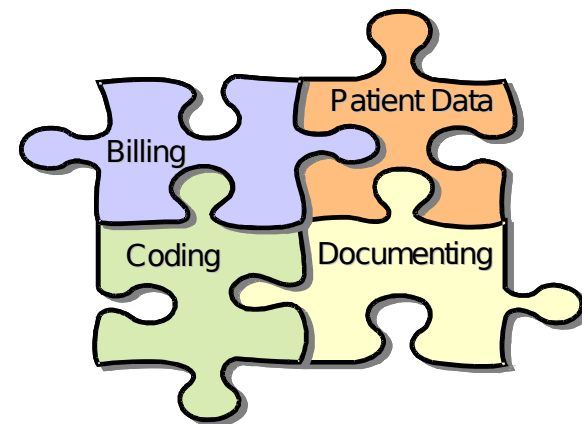
JCAHO Accreditation Manual for Hospitals (CAMH)
Information Management Standards:

* IM.6.10 requires that inpatient records be completed within the timeframe specified by hospital policy

(not to exceed 30 days)

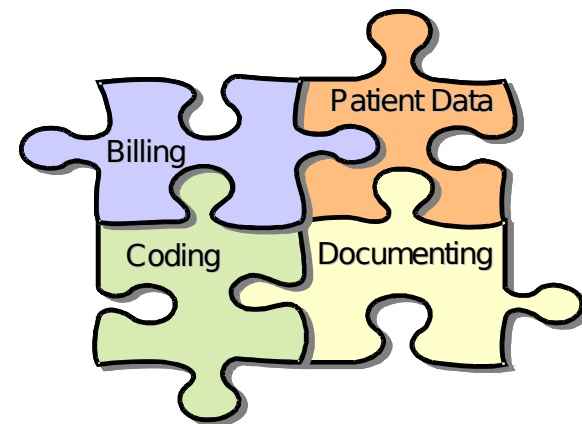
* IM.3.10 requires that the data that the hospital collects is accurate, complete, and timely.

SIDR Completion & Processing



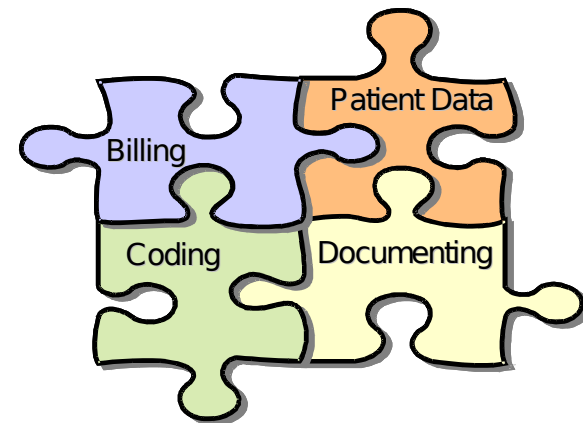
- Ensure **timely** record transmittals
 - Minimum: monthly (AF/N); bimonthly (A)
 - Executive Information Data System (EIDS) & individual Service repositories
- Ensure **complete** and **accurately** coded records
 - CHCS (Composite Health Care System) Edits
 - Consistency and validity
 - Demographics and basic ICD-9-CM coding
 - Resolve errors at MTF prior to transmittal
- Service level support
 - Service-specific edits
 - Services coordinate error resolution with MTFs

Data Quality and SIDR



- **Automated Edits**
 - **Validity and Consistency (CHCS)**
 - **Demographics and basic ICD-9-CM coding (CHCS)**
 - ***ICD-9-CM coding (Encoder/Grouper)***
- **Data Quality Management Control Program (DQMC)**
 - **DoD 6040.40, “Military Health System Data Quality Management Control Procedures”**
 - **Manual Record Reviews (Audits)**
 - **Coding & Documentation**
 - **Workload Reconciliation**

Composite Healthcare System: CHCS

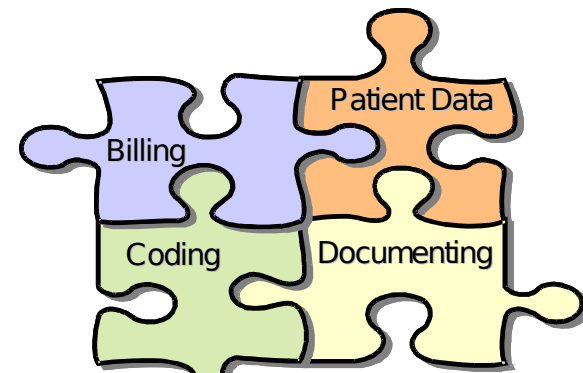


- **SIDR Layout**
 - **Six Segments**
 - **226 Fields**
 - **1326 Characters**
- **SIDR Extract**
 - **Transmitted via ETU**
 - **EIDS and Services**
 - **20 diagnoses and 20 procedures**

Table 4. SDR Segment 3

SIDR Record Layout

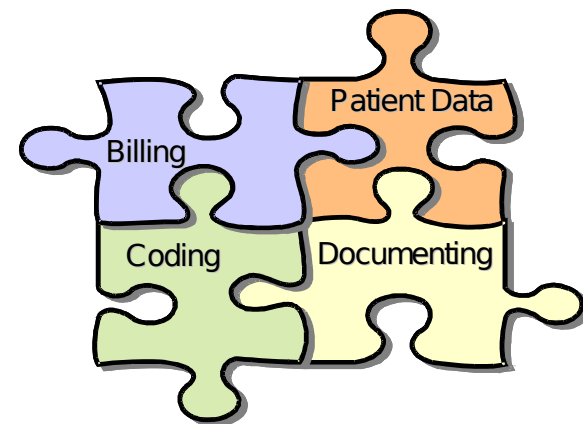
Segment 3



Position	Tape Element	Length	Type
1-5	MTF ID CODE	5	AN
6	SEGMENT NUMBER	1	N
7-13	PATIENT REGISTER NUMBER	7	N
14-16	FINAL DRG CODE	3	N
17-18	MDC CODE	2	N
19-23	GROUPE ID VERSION	5	AN
24-31	CASE COMPUTED WEIGHT	8	N
32	DIAGNOSIS #2 CC OR INDICATOR	1	AN
33	DIAGNOSIS #3 CC OR INDICATOR	1	AN
34	DIAGNOSIS #4 CC OR INDICATOR	1	AN
35	DIAGNOSIS #5 CC OR INDICATOR	1	AN
36	DIAGNOSIS #6 CC OR INDICATOR	1	AN
37	DIAGNOSIS #7 CC OR INDICATOR	1	AN
38	DIAGNOSIS #8 CC OR INDICATOR	1	AN
39	MEDICAL/SURGICAL CASE	1	AN
40-41	ENCODER/GROUPE RETURN CODE	2	AN

SIDR Matrix

CHCS Record Disposition Status



D: Patient discharged; record coded *

E: Patient discharged; record not coded **

F: Patient still hospitalized

C: Cancelled admission

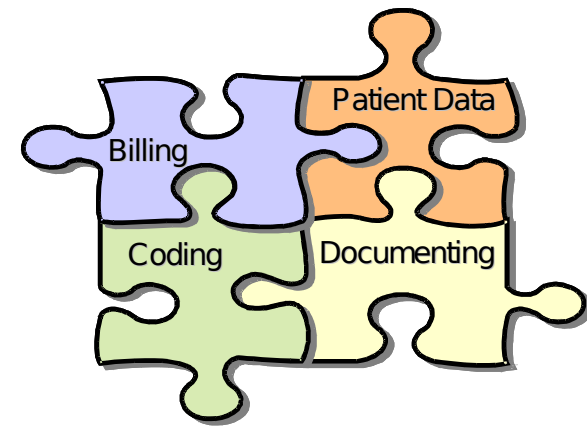
CHCS Record Versions

- Series of numbers (0-9)
- Series of alpha characters (A-Z, a-z)

*** Matrix for versions (D-0, D-1, D-2, etc.)**

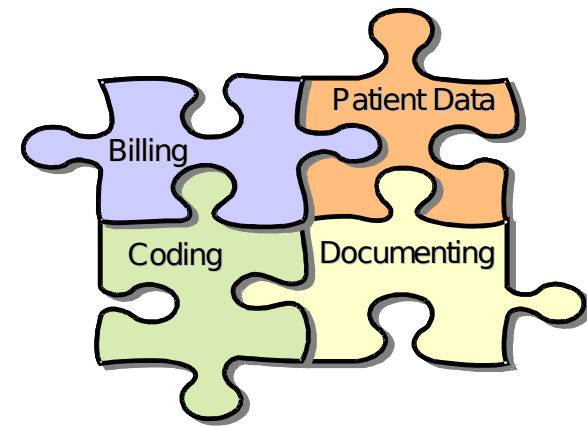
**** Demographics plus a placeholder in the 1st Dx field
(B200 = NB, B900 = Injury/trauma, B700 = All others)**

Metrics: SIDR vs. WWR



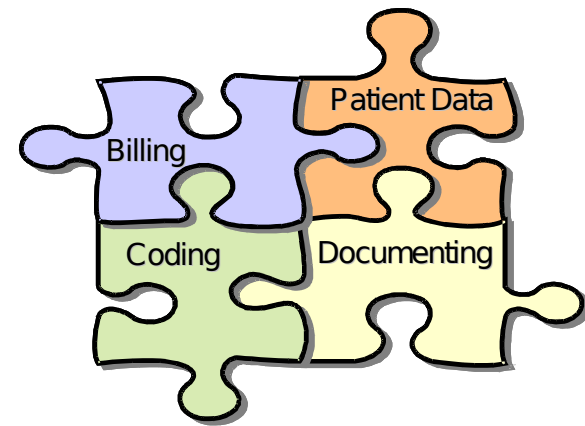
- **SIDR**
 - Completed (coded) records = "D" status in CHCS
 - A "D" record is credited against the discharge month for the inpatient stay
- **World-wide Workload Report (WWR)**
 - Summary data
 - Number of inpatient dispositions for a given month (calculate SIDR completion metrics)
 - Number of occupied bed days (calculate IBWA completion metrics)

Data Quality and Metrics



- **Data Quality Management Control Program (DQMC)**
 - Self-reported metrics
 - Timeliness, completeness, & coding accuracy
- **Coding Accuracy**
 - UBU (propose standardized coding audit methodology)
 - TMA (External peer review)

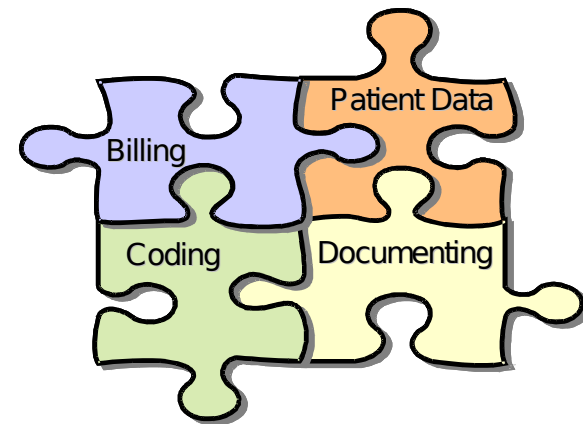
Inpatient Record Audits



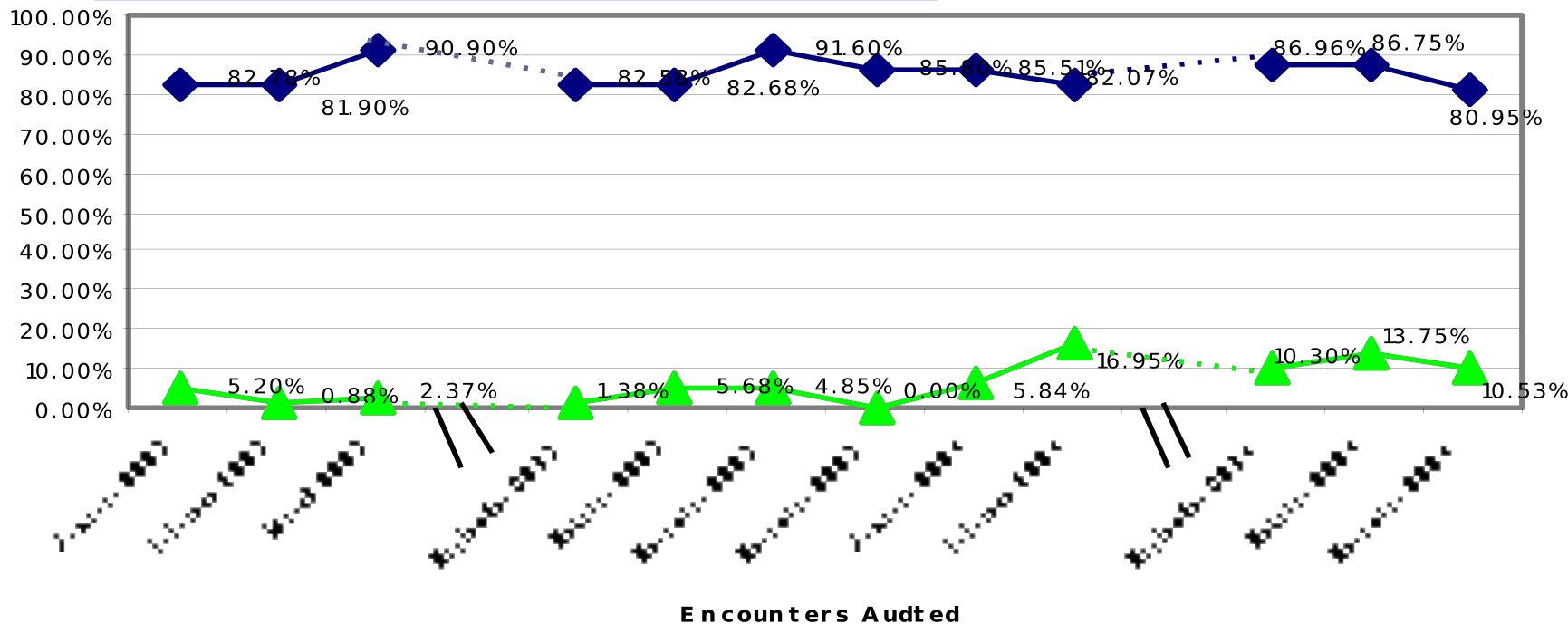
“Now, tell me why
you selected that
code?”



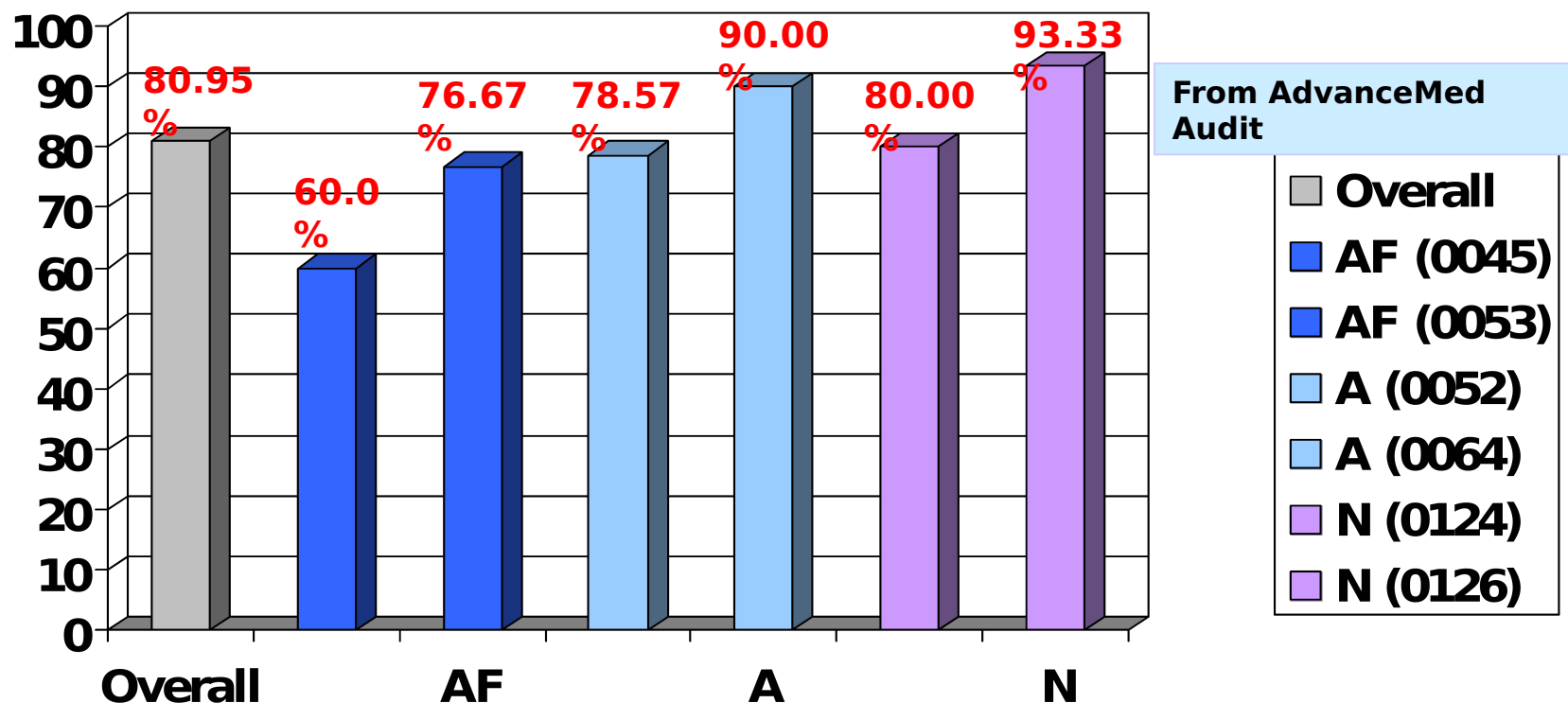
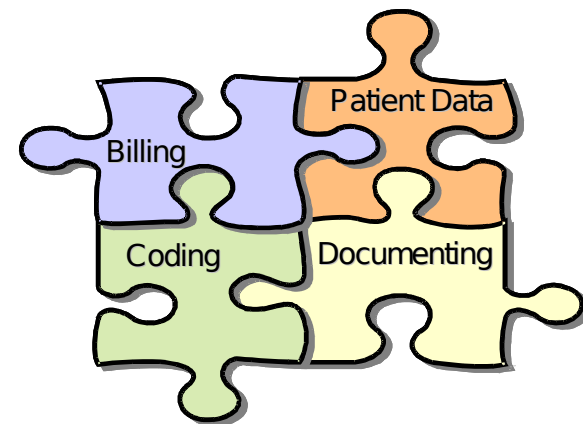
Inpatient Coding Audit Results (Jan 03 - Nov 04)



Reported through TMA peer review process



Coding Audit Results Inpatient, Nov 04

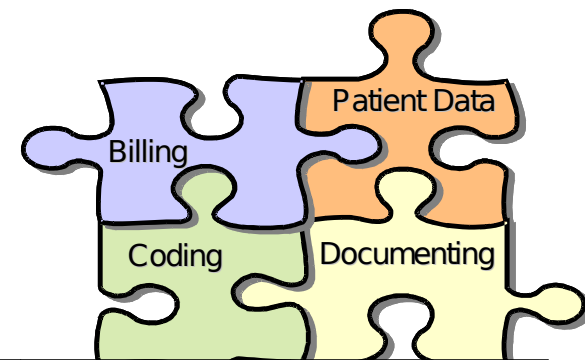


AF (n-50) 70.0%;
(n-60) 86.67%)

Army (n-58) 84.48%;

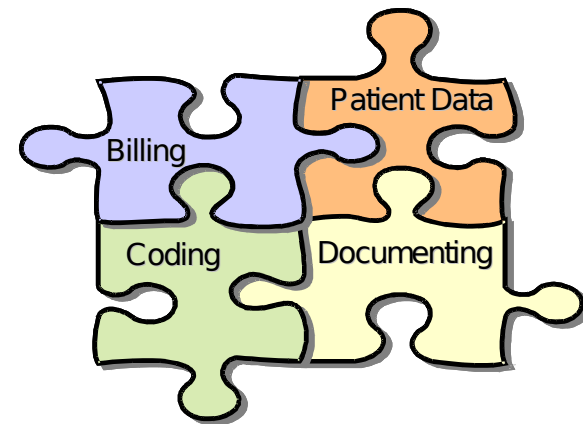
Navy

Pass Rates Overall and by Service to Date (MHS Coding Audit - TMA HPA &E)



Pass Rates Overall and by Service to Date (MHS Coding Audit - TMA HPA&E)					
Inpatient	Jan-04	Feb-04	Sep-04	Oct-04	Nov-04
Air Force - Inpatient	89.83%	86.67%	81.82%	93.33%	70.00%
Army - Inpatient	83.33%	86.27%	86.96%	93.55%	84.48%
Navy - Inpatient	81.63%	73.47%	91.67%	76.67%	86.67%
Overall Inpatient	85.51%	82.07%	86.96%	86.75%	80.95%
APV					
Air Force - APV	13.46%	5.58%	21.82%	0.00%	3.70%
Army - APV	0.00%	36.17%	5.56%	24.49%	20.34%
Navy - APV	2.17%	3.77%	3.57%	17.86%	6.90%
Overall APV	5.84%	16.95%	10.30%	13.75%	10.53%

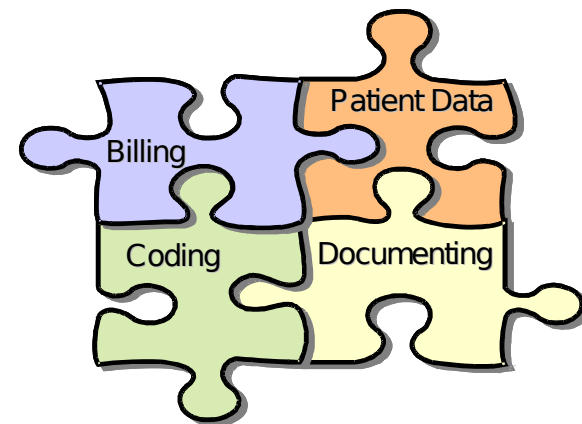
What Did the Coders Miss?



- **Code to identify allergy to medicinal agents (V14x)**
- **Code for significant medical conditions (CHF, dehydration, patient non-compliance)**
- **“E” code to identify initial treatment of an injury, poisoning, or adverse effect of drugs**
- **Code 305.1 to identify patient is a smoker**
- **Codes for history of conditions (e.g. coronary artery bypass graft)**
- **Code for conditions found on ancillary reports**
 - CT Scan

(According to TMA auditors)

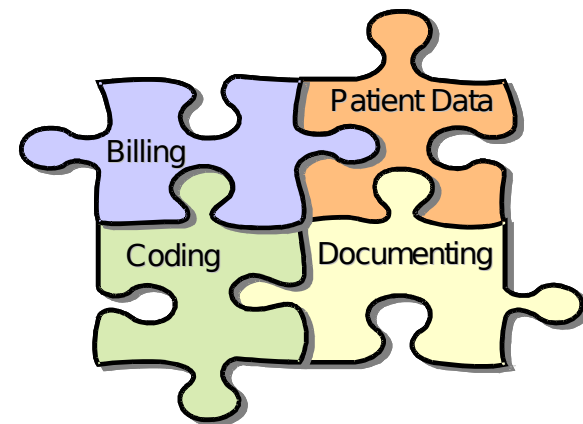
Coding Hot Spots



- Incorrect sequencing of principal diagnosis
- Failure to select combination code for acute and chronic conditions or hypertension
- Failure to identify prolonged pregnancy (>40 wks)
- Incorrect coding of Diabetes w/o complication or *manifestation*
- Poor Demographics
- Other
 - Underlying Cause of Death
 - STANAG (external cause of injury codes)
 - Late effects
 - Location of Occurrence
 - SIRS, Sepsis, Severe Sepsis & Septic Shock
 - Rules for reporting additional diagnoses

(From TMA audit results and other coding observations)

More Coding Hot Spots (procedures)



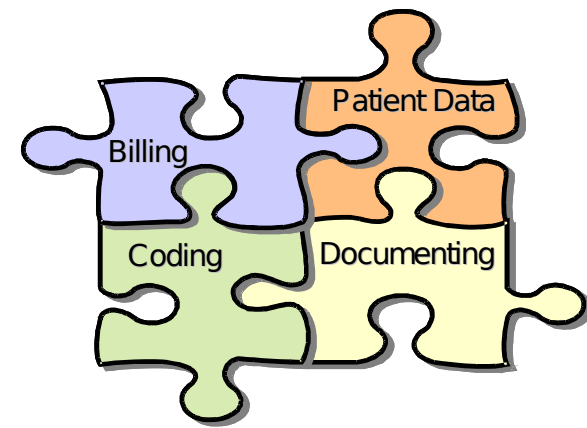
- **OB coding**
- Coding of transesophageal echocardiogram (TEE)
- Code 54.11, exploratory laparotomy should not be used if incidental to surgical procedure
- Incorrect sequencing of principal procedure
- Failure to code only “significant” procedures
- Coding of “insignificant” procedures (injections [insulin, antibiotics], CXR, BE, EKG, etc.)

(From TMA audit results and other coding observations)

Coding Support

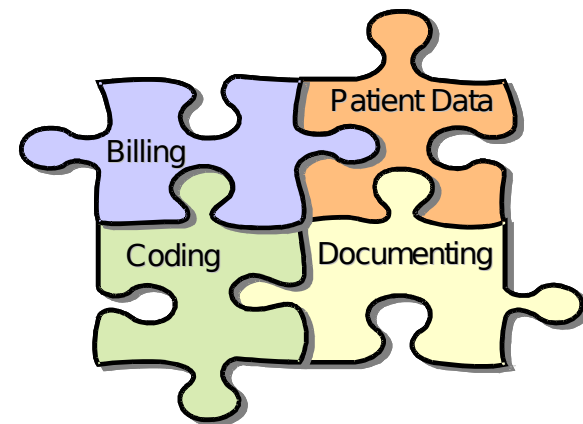
"Look, we desperately need coders. You can telecommute on flex-time if you like with all the perks and benefits. What's that? OK, we'll throw in a masseuse and hot tub."

Cartoon by Dave Harbaugh



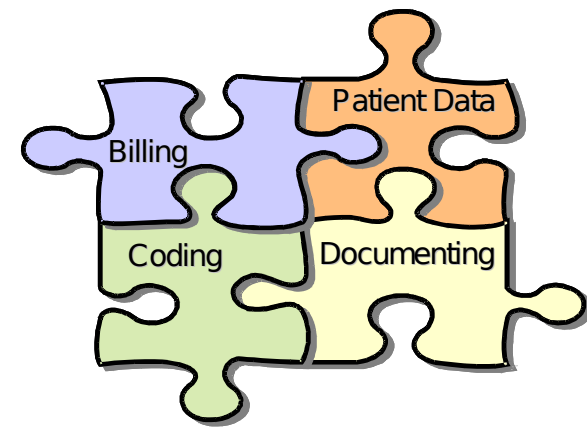
statistical Utility/Uniform
Office Conference 2005

Recommendations for Success



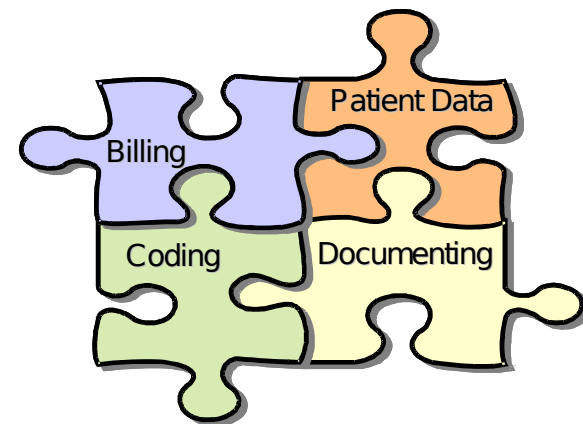
- Evaluate existing business practices
- Set up a Compliance Plan
- Incorporate Instructions, Regulations, & Directives
 - DoDD 6040.41, Medical Record Retention and Coding at Military Treatment Facilities (April 13, 2004)
 - 100% inpatient records coded within 30 days after discharge
 - 100% coding accuracy (Goal for FY06)
 - DoDI 6040.42, Medical Encounter and Coding at Military Treatment Facilities (June 10, 2004)
- Monitor

Validate Coding Accuracy



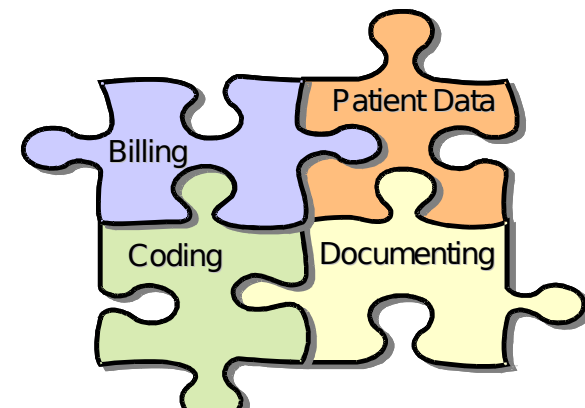
- **Audit the data (internal, external)**
- **Perform focused audits**
 - **Selection of principal diagnosis**
 - **Selection of principal procedure**
 - **Selection of secondary diagnoses (documentation)**
- **Review Office of Inspector General (OIG) Work Plans - 6th Scope of Work (SOW)**
 - **Appropriateness of admission (medical necessity)**
 - **One-day stays (<24 hours)**
 - **Targeted DRGs**
- **Train and educate**

PPS and DRGs



- **PPS - Prospective Payment System**
- **DRGs - Diagnosis Related Groups**
- **Focused DRG audits**
 - <http://oig.hhs.gov/oei/atod.html>
 - <http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf>
- **Federal Register, 4 May 05, Proposed Rules for 06**
<http://www.cms.hhs.gov/providerupdate/regs/cms1500p.pdf>

Highly vulnerable DRGs



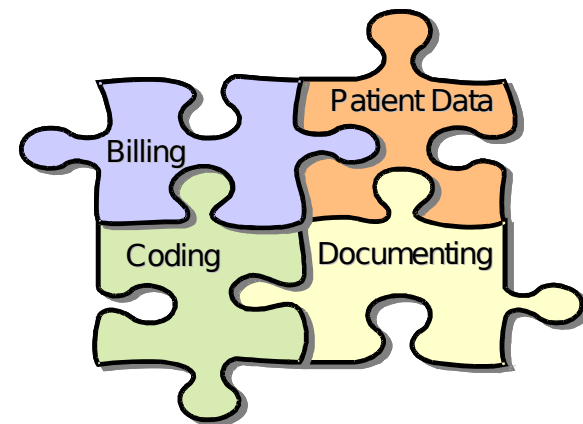
difference between upcoding and downcoding in these hospitals suggests intentional abuse of the DRG system by some providers.

- Using data from both our focused review and the more broadly representative 1996 DRG validation performed by HCFA's clinical data abstraction centers (CDAC), we found that certain DRGs are particularly susceptible to upcoding.

Three Highly Vulnerable DRGs						
	OIG Experimental Sample		OIG Control Sample		CDAC Sample	
	Up-coded	Down-coded	Up-coded	Down-coded	Up-coded	Down-coded
DRG 79: Respiratory Infections	37.7% (n=60)	0.0% (n=0)	18.5% (n=5)	0.0% (n=0)	11.0% (n=48)	0.7% (n=3)
DRG 416: Septicemia	21.2% (n=14)	0.0% (n=0)	16.7% (n=3)	0.0% (n=0)	13.3% (n=49)	1.1% (n=4)
DRG 14: Specific Cerebrovascular Disorders	10.1% (n=10)	0.0% (n=0)	6.7% (n=2)	0.0% (n=0)	3.5% (n=24)	0.4% (n=3)

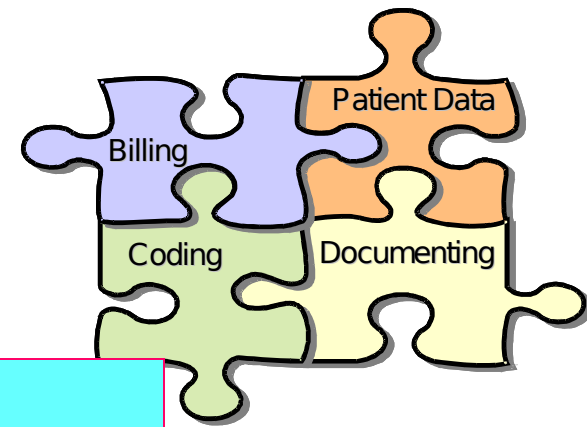
Taken from OIG website

Look to the Future



- Update DoD Coding Guidelines (UBU)
- Standardize Coding Audit Methodology (UBU)
- CCE for Inpatient
 - 3-M product
 - Medicare edits
- ICD-9-CM updates for FY06 (October 05)
- AHIMA's 77th Convention and Exhibit
 - October 15-20, 2005 in San Diego, CA
 - TRISVC Day, Thursday 20 October

In Summary...



You don't have to review hundreds of medical records



Full Participation in DQMS

Monitor the Data

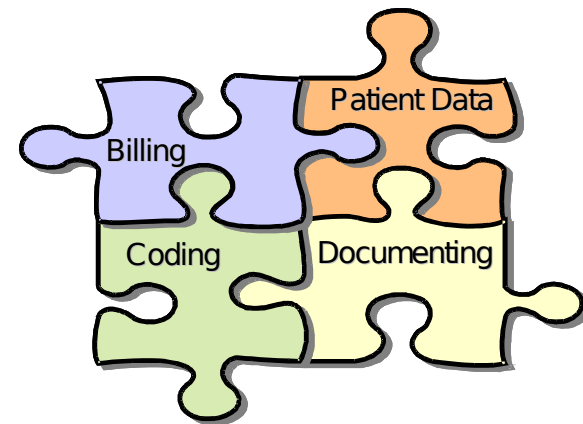
Correct

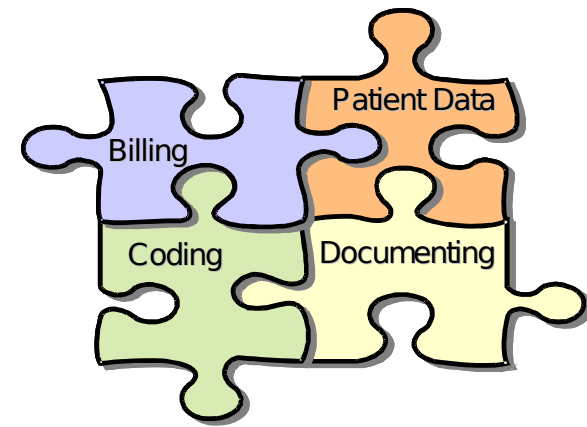
Accurate SIDR data

GREAT STATISTICS for USe!

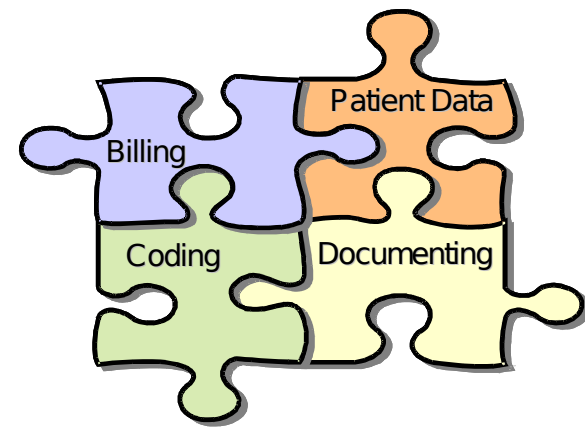
Service POCs for SIDR

- **Army**
 - Royce Staley, RHIA
 - Royce.Staley@amedd.army.mil
 - Comm: 210 ; DSN
- **Navy**
 - Ciel Lazo, RHIA
 - CVLazo@US.MED.NAVY.MIL
 - Comm: ;DSN 762-3145
- **Air Force**
 - Debi Yowell, RHIA, Medical Record Consultant
 - Debi.yowell@brooks.af.mil
 - Comm: 210 536-4081; DSN 240-4081
 - Alicia C. Garza, RHIA, Medical Record Specialist (SIDR)
 - Alicia.garza@brooks.af.mil
 - Comm: 210 536-4023; DSN 240-4023





QUESTIONS ?

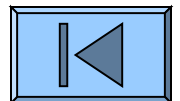


Coding from the Trenches

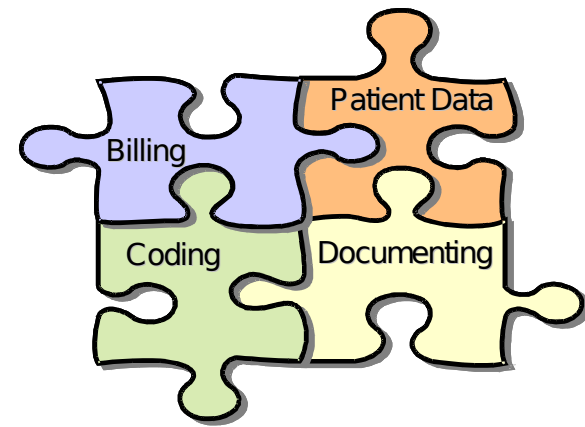
Lesvia O Millican, CPC, PMCC

May 17th 2005

Track 1, UBU

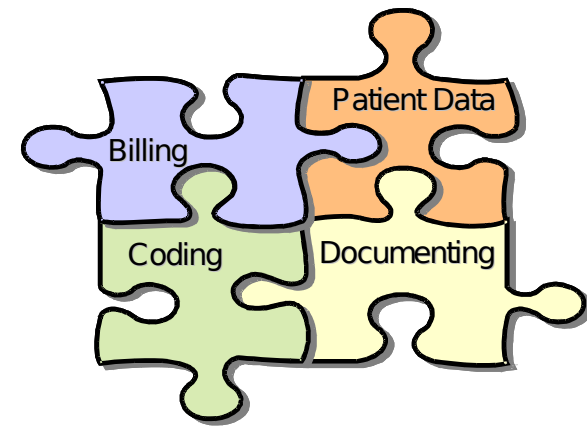


Objectives



- MHS vs. Civilian Coding
- DoD Coding
- MHS Challenges
- Standardization
- Summary

MHS vs. Civilian

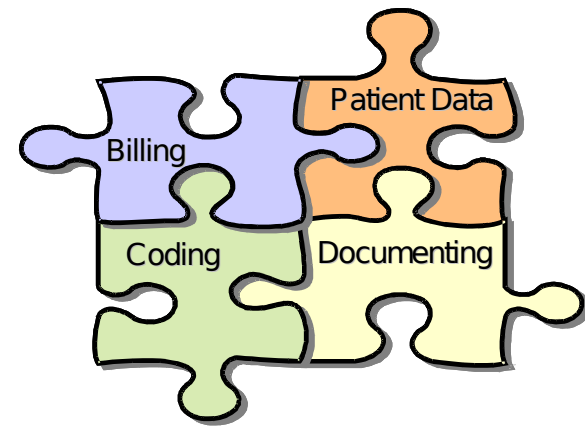


- **Number 1 Rule**

DoD Guidelines supercede all others !!!

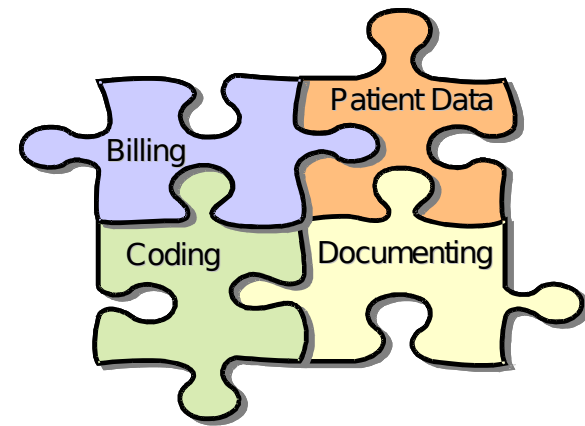
If DoD guidelines are silent follow all official Coding Guidelines in effect for the time of the service.

MHS vs. Civilian cont'd



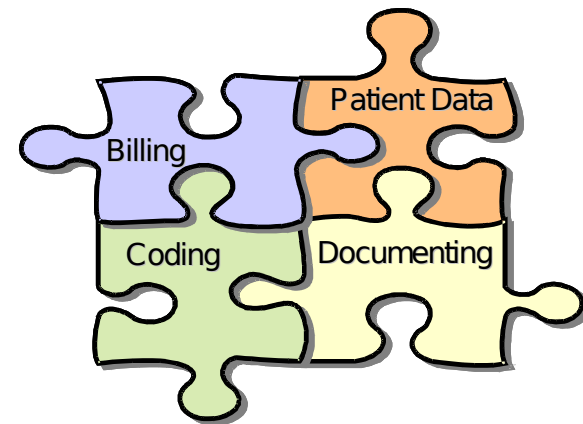
- Civilian Coding Guidelines based on direction from:
 - ICD-9-CM
 - CPT
 - HCPCS
 - CMS Guidelines

MHS vs. Civilian cont'd



- CMS Coding Guidelines for Reimbursement
- Coding Resources
- Additional Resources
- Standardization

DoD Coding Guidelines



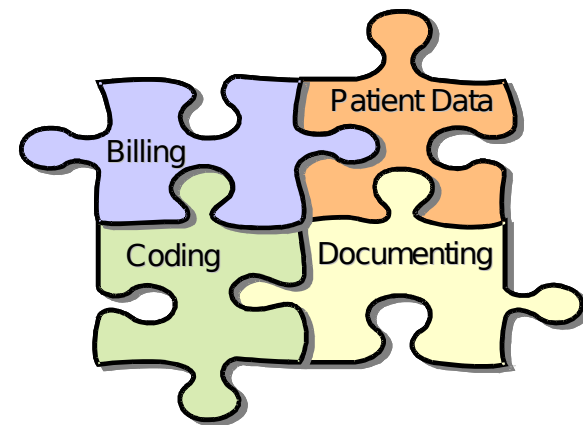
- DoD Coding Guidelines are derived from the following source documents:
 - International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM),
 - Current Procedural Terminology (CPT), 4th Edition,
 - Centers for Medicare and Medicaid Services (CMS) Documentation Guidelines for Evaluation and Management (E&M) Services,
 - HCPCS (Healthcare Common Procedure Coding System),
 - The American Hospital Association (AHA) Coding Clinic,
 - The CPT Assistant
 - The Coding Clinic for Healthcare Common Procedure Coding System (HCPCS).

NOTE:

These guidelines supplement, not substitute for, DoD guidance. Unified Biostatistical Utility/Uniform

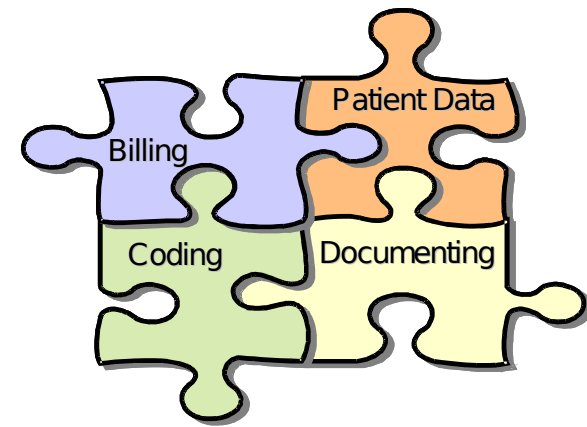
Business Office Conference 2005

DoD Coding Guidelines



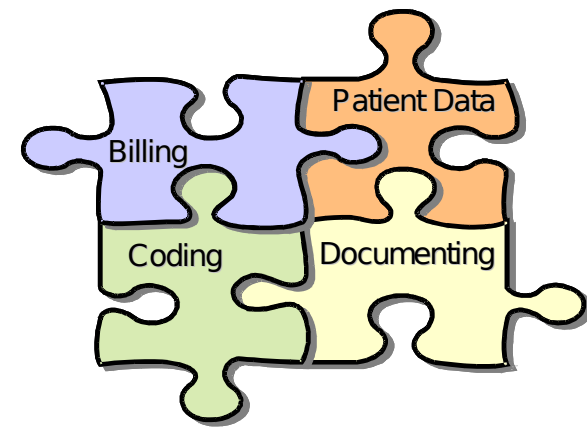
- The Department of Defense (DoD) Coding Guidelines provides guidance for coding professional services.
- The Military Health System (MHS) is shifting from capturing inpatient and outpatient clinical services to capturing institutional and professional services.
- Updates to coding guidance may be found on the UBU website which is located at the following url:
- <http://www.tricare.osd.mil/org/pae/ubu/default.htm>

Diagnosis Coding



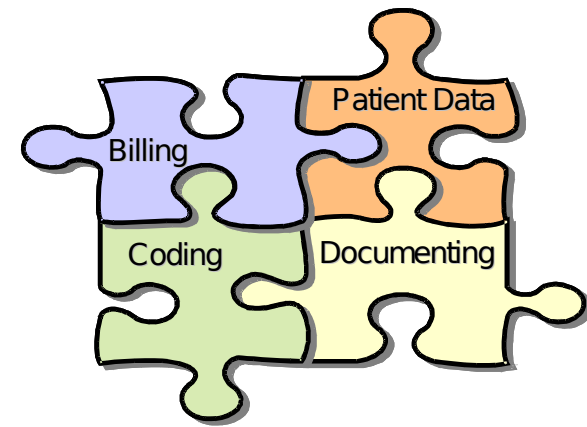
- ICD-9 format
 - Vol 1 Tabular list Disease
 - Vol 2 Alpha list Disease
 - Vol 3 Tabular list and procedure index
- Volume 1 & 2 used for provider coding (out patient coding)
- Volume 3 used for inpatient coding

Diagnosis Coding cont'd



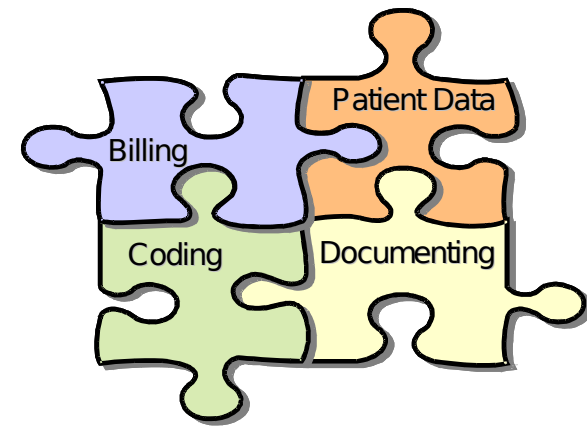
- Look up the main term/diagnosis in your Alpha Index of Diseases, Vol 2.
 - Example: otitis media
 - congestive heart failure
 - headache
- Civilian - Code for the disease as primary, w/ specificity
- MHS - If related to deployment, code DoD extender codes primary, for tracking

Diagnosis Coding cont'd



- Find term in the alpha index, turn to tabular listing with codes
 - Example: Otitis Media... 382.9
not further indicated as to acuity or specificity?
Prompt: Train w/ providers to further specify if possible
 - Example: Otitis Media: allergic 381.4

Diagnosis Coding cont'd

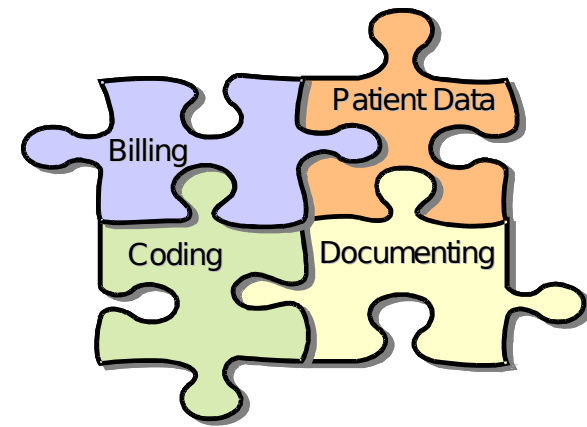


- **Example:**

- Otitis Media... 382.9
 - Further specified.....
 - Otitis Media: allergic 381.4
- Pre-Deployment Examination.....
 - DoD Extender Code.....V70.5_4
 - 2ndary diagnosis..... 381.4

DoD Coding Guidelines always supercede
official Coding Guidelines

Diagnosis Coding cont'd

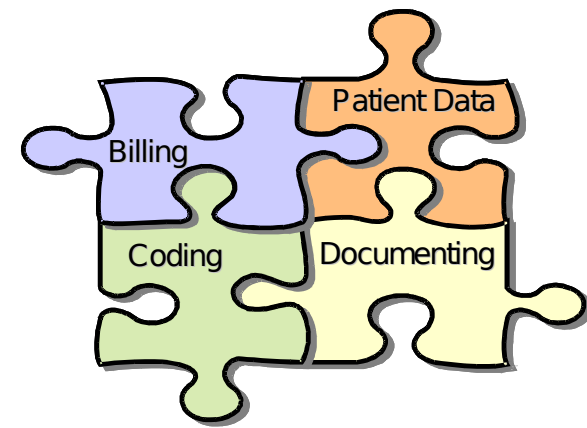


- If not Documented you can not code it!

Never assume a code if it is not specified!

- All codes which indicate an underlying disease must be coded with both codes.
 - Example: Diabetes Mellitus, w/ renal failure
 - Code: 250.40 (underlying disease)
 - Code: 585- renal failure (manifestation code)

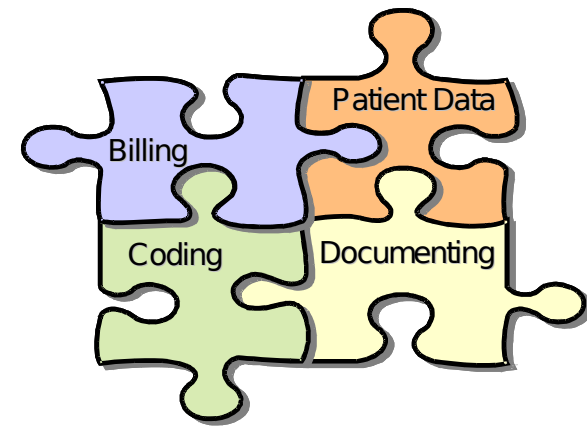
Diagnosis Coding cont'd



Diagnosis are to be assigned w/
specificity

- 3-digit code is only used if not further subdivided
- Invalid if not coded to 4th or 5th digit
 - Example:
 - 410 – myocardial infarction – (invalid alone)
 - 410.2 – of infer lateral wall
 - 410.21– initial episode of care

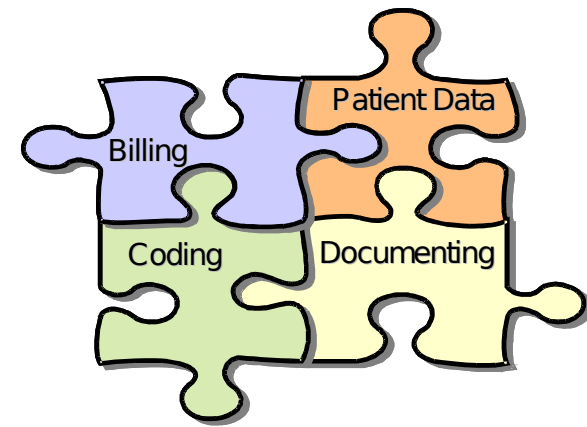
Diagnosis Coding cont'd



- Most Codes ending in 9 are unspecified
 - Example:
 - 590.9- infection of kidney, unspecified
 - 761.9- unspecified maternal complication of pregnancy affecting fetus or newborn
- Use V codes from the Supplementary Classifications as needed
 - Example:
 - V11-Personal history of mental disorder
 - V62.4- Social maladjustment

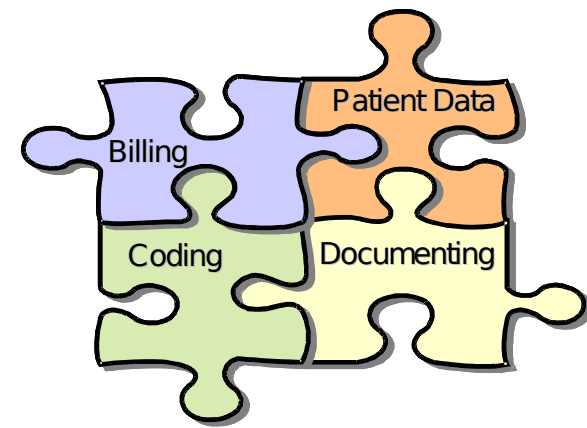
Note: Instructions on how to use V codes are defined in the front of your ICD-9-CM book

Diagnosis Coding cont'd



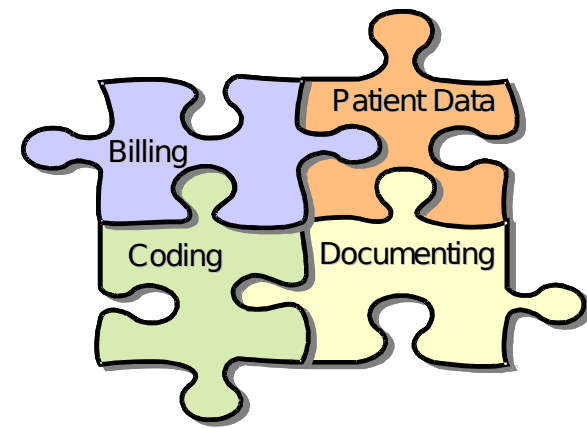
- Use E Codes from External Cause Section
 - Civilian-These codes are to be reported at the initial encounter only.
 - Military-DoD Coding Guidelines direct the facility to use the E Codes at first MTF encounter even if a patient has been seen in a civilian facility
 - Never used as primary diagnosis
 - Use as many E codes as needed to fully describe the external cause

Evaluation & Management Services



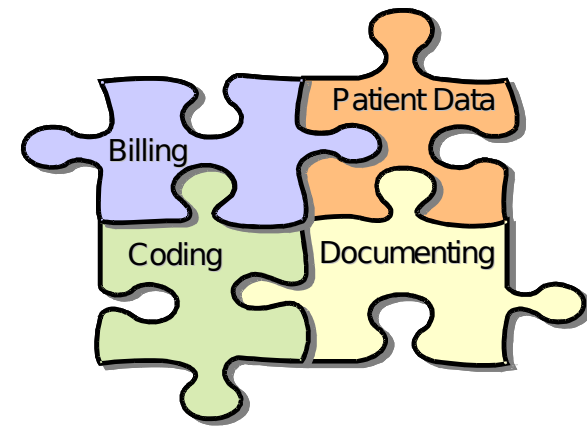
- An E&M code is currently required for each encounter.
- 99499 – placeholder, indicates the encounter without a code from the E&M section
- Privileged provider encounters with such limited documentation as to only support a 99211 will be coded with a 99211 (civilian is used primarily for nurse encounters)
- Non-privileged providers are normally restricted to using E&M code 99211 to document face-to-face encounters in which there is no procedure performed

Evaluation & Management Services cont'd



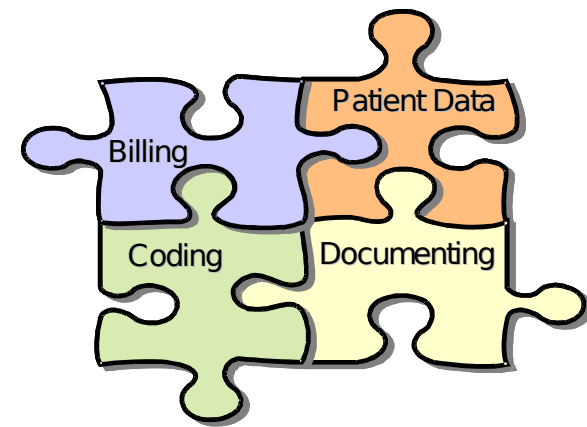
- Coding for DoD healthcare services:
 - Substitute the term “privileged providers” where CPT manual description uses the term “physicians.”
 - Privileges are granted by individual military treatment facilities (MTFs).
 - Privileged providers include:
 - licensed physicians
 - advanced practice nurses
 - physician assistants
 - oral surgeons
 - Optometrists
 - residents [other than post graduate year one (PGY-1)]
 - physical and occupational therapists

Evaluation & Management Services cont'd



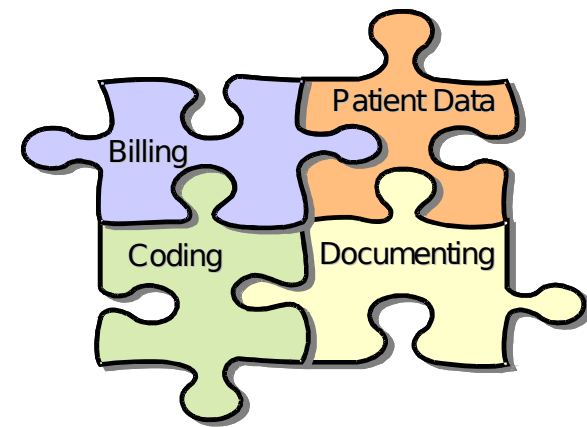
- Evaluation levels
 - Established patient needs 2 out of 3 key components
 - New patient must have all 3 components
 - Record should be legible and clearly documented
 - Template/Overprints are acceptable
 - Providers must sign and date documentation.

Evaluation & Management Services cont'd



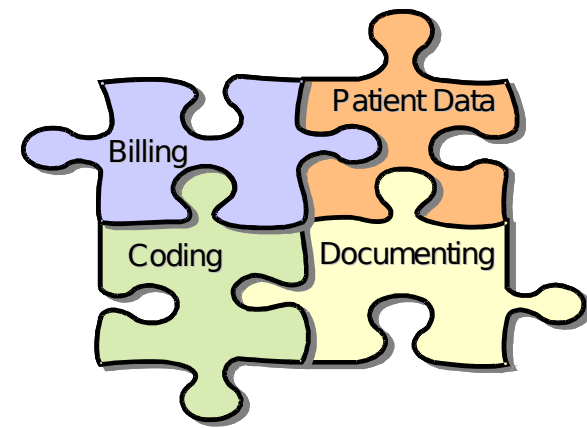
- 99201-99215: E&M services provided in office, outpatient or urgent care settings
- 99211: most abused code, DO NOT use for:
 - T-cons
 - Prescription renewals
 - Not medically indicated pulse, temperature or blood pressures

Evaluation & Management Services cont'd



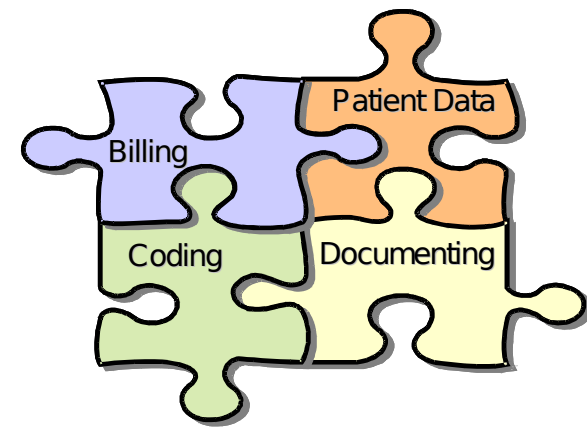
- 99241-99245: Consultation services provided
 - Office
 - Outpatient
 - Emergency roomThe three R's...Request, Render and Response
- Examples that do not meet the criteria for Consultations
 - Standing orders in the medical record for consultations
 - No order for consultation
 - No written report of a consultation

Evaluation & Management Services cont'd



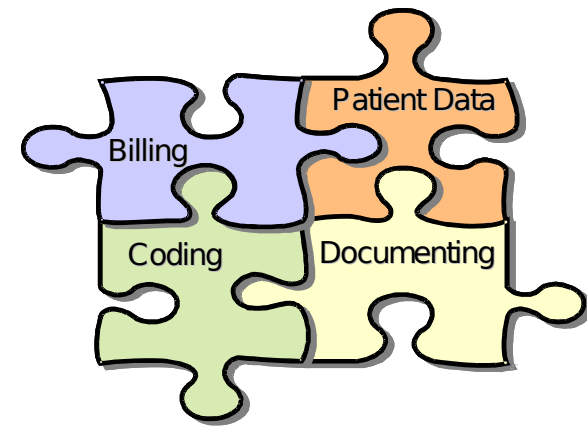
- 99251-99255 – Inpatient Consultations
- 99261-99263-Follow-up Inpatient Consultations
- 99218-99220 – Initial Observation Care
- 99217 - Observation Care Discharge
- 99234-99236 – Obsv or Inpatient Care Services
 - Patients admitted and discharged same day

Evaluation & Management Services cont'd



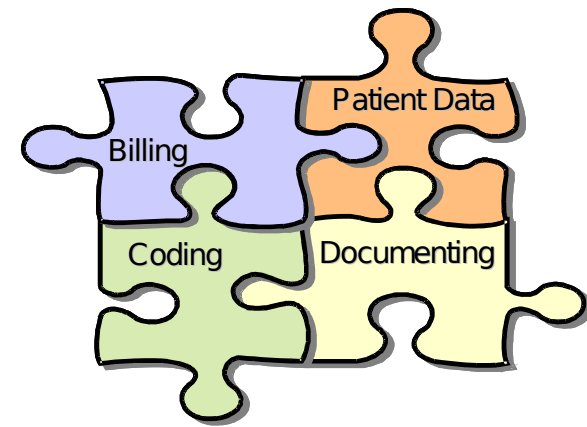
- 99211-99223 Initial Hospital Care
- 99231-99233 Subsequent Hospital Care
- 99238-99239 Hospital Discharge Services
- 99281-99285 Emergency Dept. Services

Evaluation & Management Services cont'd



- 99291-99292 Critical Care Services
 - Coronary unit
 - Intensive care unit
 - Respiratory unit
 - Emergency department
- 99381-99397 Preventative Medicine Services
 - Can be used in conjunction with 99201-99215
 - Modifier 25 required

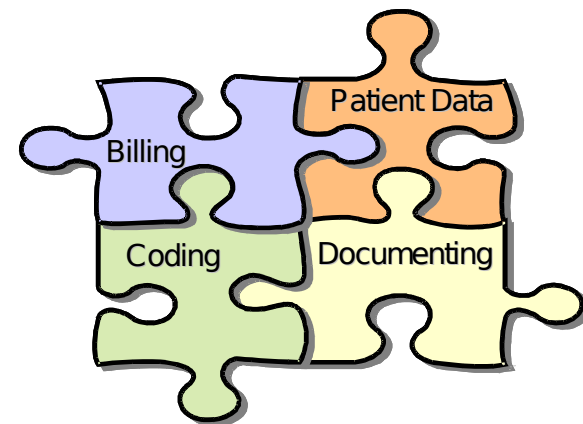
GME Teaching Physician Rules Evaluation Services



General Rule:

- Statement of presence may be noted on record by resident, nurse or physician for procedures
 - For Surgical, high risk/complex procedures, must be present during all critical portions, and immediately available for all other portions of procedure
 - Teaching physicians presence not required during opening and closing of surgical field
 - Endoscopies, teaching physician must be present for entire viewing
 - Evaluation and Management, TP must be present for the portion of service which determines level for billing, in hospital outpatient departments
 - E/M services must reflect personally document participation, by TP at time of service

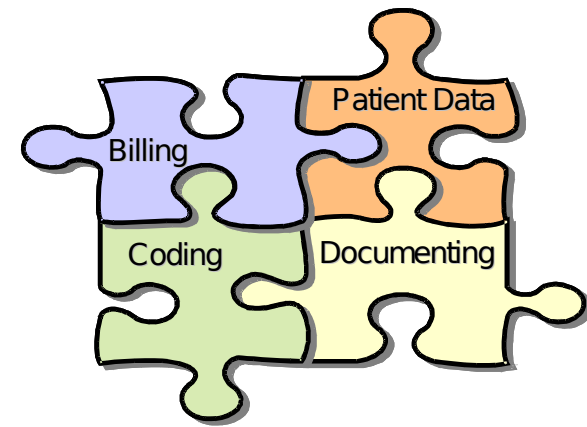
Coding for Procedures



- CPT- Current Procedural Terminology
 - Used for reporting procedures performed during encounter, must be fully documented
 - Modifiers may be appended as needed to further describe a procedure or alteration of services performed
 - CPT is assigned a Relative Value Unit for re-imbursement

Note: Civilian: relies on re-imbursement based on RVU
MHS: relies on RVU assigned for Biz Plan

Coding for Procedures cont'd



- Sutures (see repair)

- simple
- layers of closure
- complexity

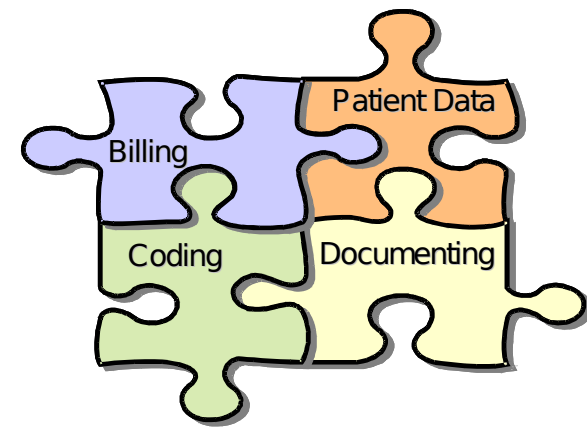
Record in centimeters; debridement is included unless otherwise specified

- Debridement

- Contamination
- Surgical

Considered part of wound repair except when gross contamination

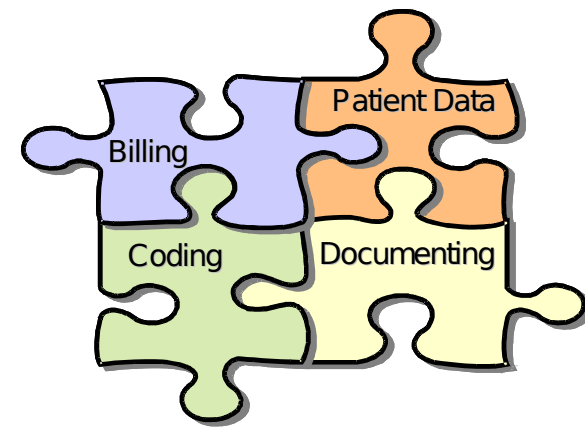
Coding for Procedures cont'd



- Endoscopy- Indicate anatomical sites
 - Diagnostic
 - exploration
 - dilation
 - Surgical
 - biopsies
 - removal
 - destruction

Surgical endoscopies include diagnostic
- Use of Operating microscope
 - Add on code

Coding for Procedures cont'd

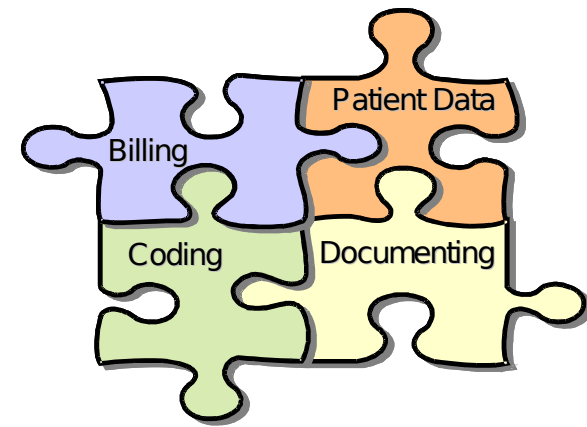


- Diagnosis pertinent to procedure
 - 32658 Thoracoscopy; surgical
 - 420.91 Acute idiopathic pericarditis
- Indicate if post op visit
 - 99204-normally included in surgical package

Use appropriate modifiers to depict the individual procedure

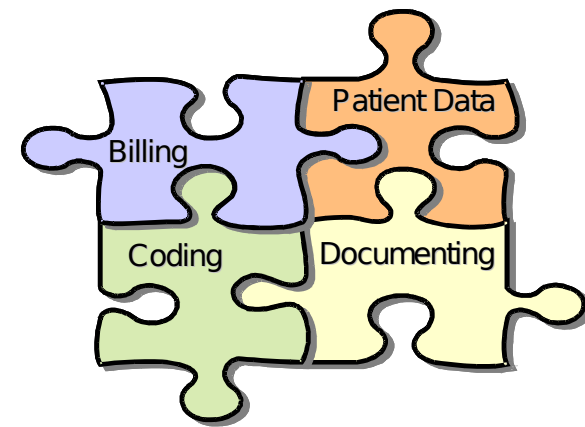
performed during a post operative period, 58, 78, 79

Coding for Procedures cont'd



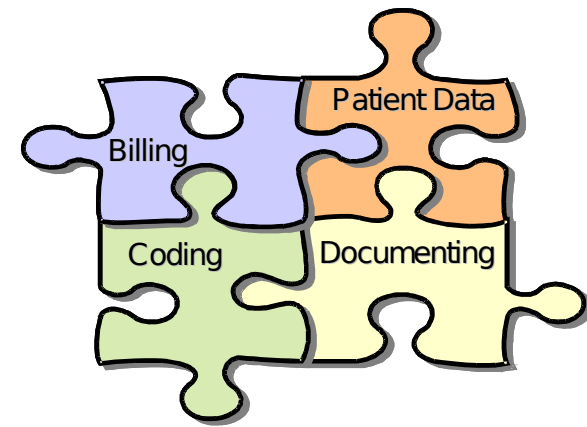
- E/M with a procedure
 - Clearly document services were separately identifiable
 - Modifier -25
 - Minor procedure
 - Pre operative period
 - Post operative period

HCPCS



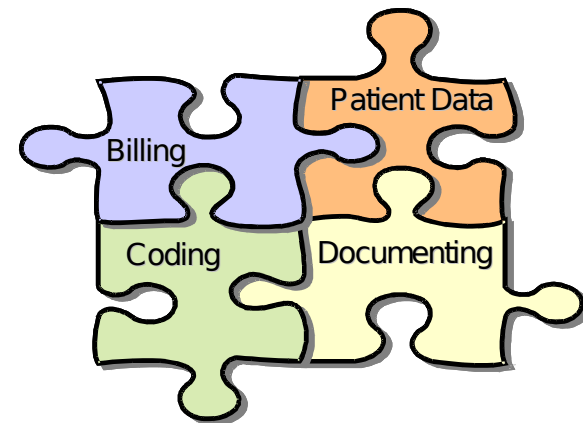
- Healthcare Common Procedure Coding System
 - Developed in 1983
 - Used to report professional services, supplies or procedures
 - Updated on a yearly basis, (as is all other coding/CPT manuals)
 - All HCPCS consist of an Alpha character and four digits
 - Level I codes are used to report medical services and supplies to Medicare, Medicaid and private payers
 - National Modifiers can be used with all levels of HCPCS

HCPCS Modifiers



- Appendix 1 in HCPCS
- Most commonly used:
 - RT right side of body
 - LT left side of body
 - E1 – E4 identify sites of eyelids
 - F1 – FA identify digits of hands, RT and LT
 - T1 – TA identify foot, toe, digit, RT and LT

Modifiers



Most common CPT modifiers:

- 21- prolonged counseling
- 25 – Evaluation and procedure same encounter
- 50 – Bilateral procedures
- 51 – Multiple procedures, results in fee reduction
- 57 – Decision for surgery, surgery usually done same day
- 59 – procedures/services not usually performed at the same time

* Up to three modifiers may be used for each procedure

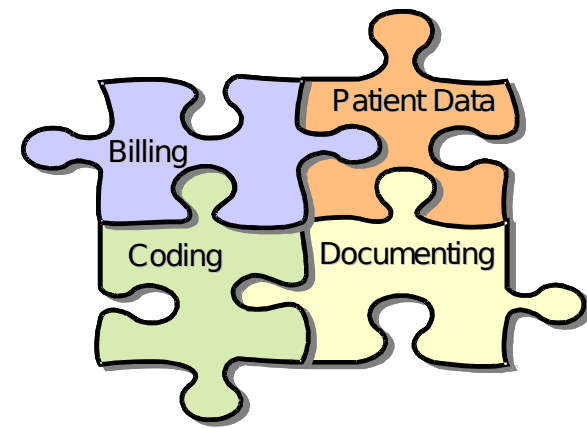
Note: For additional available modifiers see your FY05 DoD

Coding Guidelines

Unified Biostatistical Utility/Uniform

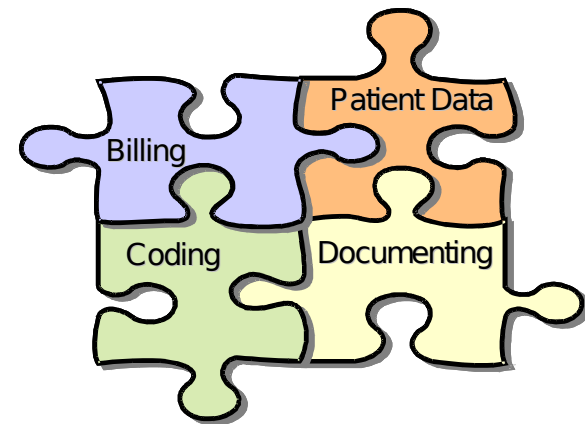
Business Office Conference 2005

DoD Coding Guidelines cont'd



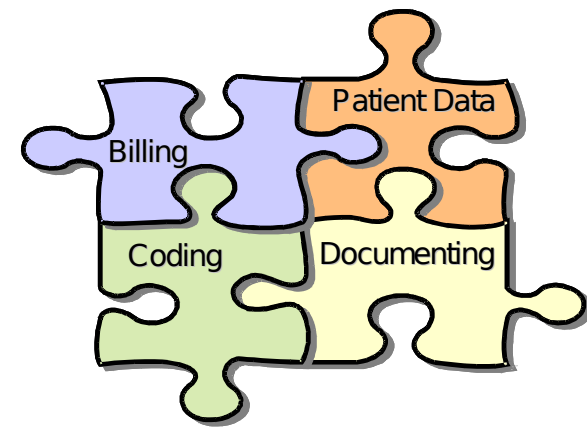
- Level II codes supersede Level I codes for similar encounters, when the verbiage of the Level II code is more specific
- HCPCS include evaluation and management services, other procedures, supplies, materials, injectables and dental codes
- Code number in a specific section does not usually restrict its use to specific profession or specialty

DoD Coding Guidelines cont'd



- How to report modifiers:
Example: Cardiology Lab;
EKG: read and interpretation;
93010-26
technical component;
93005-TC

DoD Coding Guidelines cont'd

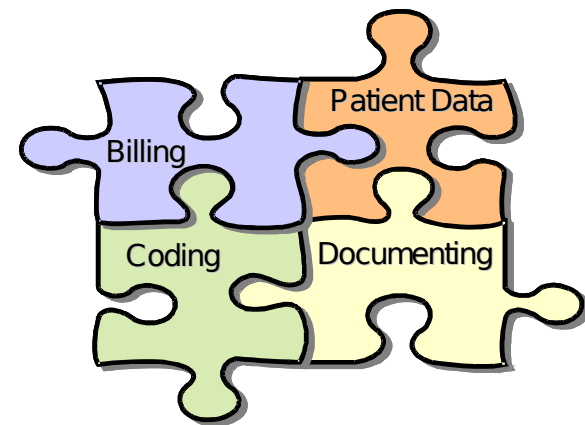


If more than one level II HCPCS modifier applies, repeat CPT code w/ additional modifier

Example: code 26010, Drainage of finger abscess; simple, done on left hand thumb and second finger.

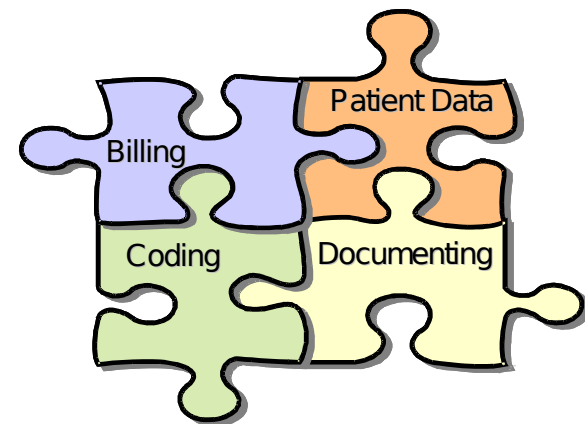
- Civilian: 26010 - FA
26010 - FI
- DoD: 26010 -FA, FI

MHS Challenges



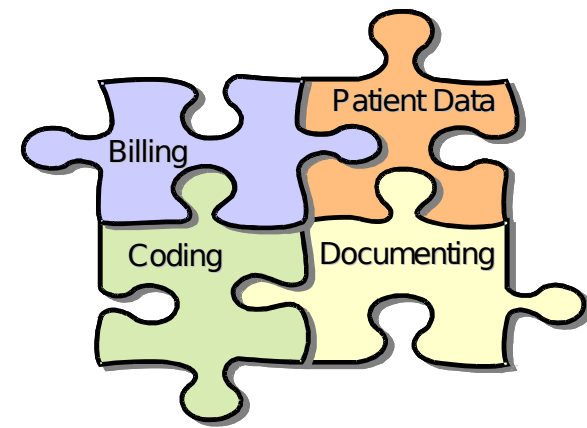
- MTF- No Coders
- MTF- Limited Coders
- MTF's w/ Limited Qualified Coders
- Changing Guidance
- Conflicting Guidance

MHS Challenges



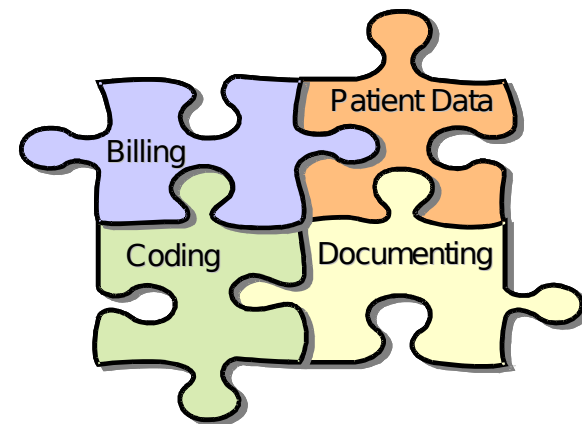
- Systems Limitations
- Automated Systems
- Multiple Organizational Involvement
- Maintain Revenue Cycle
- Maintain Data Quality
- Accurate Workload Accountability

Standardization



- External Audits
- Internal Audits
- Workload
- Data Quality
- Billing

References



Army

<http://www.pasba.amedd.army.mil>

Air Force

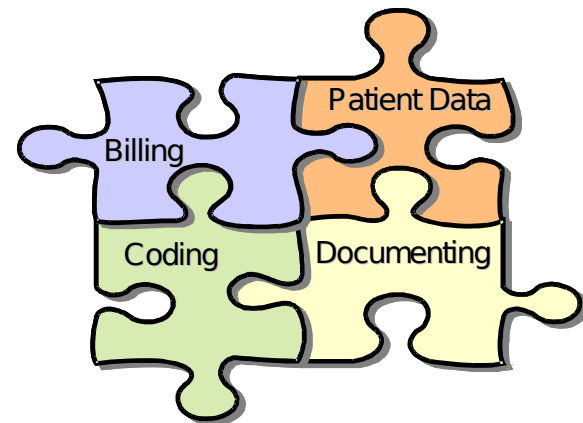
<https://phsohelpdesk.brooks.af.mil>

1-800-298-0230

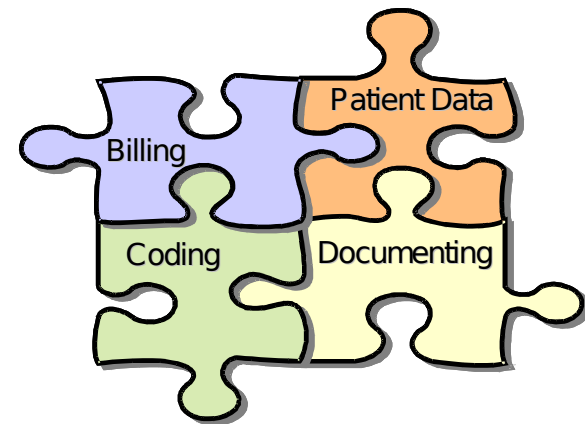
Navy

<https://imcenter.med.navy.mil/045department/>

Summary



- Civilian Coding
- DoD Coding
- Coding Services
- Challenges
- Standardization



Questions?